MONTANA CANCER CONTROL PROGRAMS

Policy and Procedure Manual

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Montana Cancer Control Programs
Department of Public Health and Human Services
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1 MONTANA CANCER CONTROL PROGRAMS

The Montana Cancer Control Programs

The Montana Cancer Control Programs (MCCP) is a part of the Chronic Disease Prevention and Health Promotion Bureau in the Montana Department of Public Health and Human Services. The Montana Cancer Control Programs include the Comprehensive Cancer Control Program, the Cancer Screening Program and the Cancer Surveillance and Epidemiology Program. The MCCP receives grant funding from the Centers for Disease Control and Prevention and State Special Revenue funds to implement cancer control activities.

A. Comprehensive Cancer Control Program

The Comprehensive Cancer Control Program coordinates a statewide collaborative effort to implement the Montana Comprehensive Cancer Control Plan. Comprehensive Cancer Control is broadly defined as "a coordinated approach to reduce the incidence, morbidity and mortality of cancer through prevention, early detection, treatment, rehabilitation and palliation". This approach integrates multiple disciplines including administration, research, clinical services, evaluation, health education, program development, grassroots services, data analysis, public policy, surveillance and health communications in a coordinated cooperative effort to address cancer prevention and control in Montana.

- **Local Contractors**
  The MCCP has thirteen contractors statewide implementing Comprehensive Cancer Control throughout the state of Montana. This is accomplished by building local coalitions, implementing public education activities, partnering with organizations or systems to achieve increased cancer screening rates and performing evidence-based cancer control activities.

- **Montana Cancer Control Coalition**
  The Montana Cancer Control Coalition (MTCCC) is a group that represents a broad spectrum of partners who want to reduce the burden of cancer in Montana. The Coalition works together to implement Montana's Comprehensive Cancer Control Plan. Currently there are over 160 members. The MTCCC includes cancer survivors, caregivers, medical professionals, hospital administrators, legislators, representatives of nonprofits, the Department of Public Health and Human Services (DPHHS), private and public organizations and other health advocates – all sharing their knowledge, experience and expertise. There are biannual statewide MTCCC meetings.

- **Statewide Partnerships**
  The MCCP is establishing partnerships to address cancer prevention and control by reducing duplication of services and maximizing resources available. Partnership activities include education, influencing decision makers, collecting and sharing data and implementing systems change for increased cancer screening rates.

B. Cancer Screening Program

The Cancer Screening Program supports comprehensive cancer control in Montana by providing ongoing quality screening services to Montana men and women and education in a manner that is appropriate, accessible, cost-effective and sensitive to the client's needs. Screening services include mammograms, clinical breast exams, Pap tests and pelvic exams for the early detection of breast and cervical cancers and colonoscopies and FOBT tests for the early detection of colorectal cancer. Diagnostic testing is also provided for the follow-up of abnormal screening tests. The eligibility guidelines for enrolling in the screening program include age, income and insurance.

- **Local Contractors**
  The MCCP has thirteen local contractors located throughout the state of Montana. The contractors provide and facilitate screening support activities for eligible Montanans, maintain a medical service provider network by enrolling qualified medical service providers to provide colorectal, breast and cervical cancer screening services and collect data on the screening services provided.

- **Medical Service Providers**
  The MCCP has 900 enrolled medical service providers who practice in all parts of Montana. These providers provide colorectal cancer screening to men and women and breast and cervical cancer screening services to women in the targeted age and population including those providing services through the Indian Health Service or tribal health.

- **American Indian Screening Initiative**
  The MCCP established the American Indian Screening Initiative (AISI) in year 2000 to focus on the screening of American Indian women. As part of the AISI, the leadership of the Montana Breast and Cervical Health Program initiated the formulation of the Montana American Indian Women's Health Coalition (MAIWHC). In early March and June 2001, they brought together 25 Indian women, representative of their Tribal Communities and Tribal Health Systems, Urban Health Programs and Urban Communities. The MAIWHC is a grassroots coalition to assist MCCP in recruitment and screening of American Indian women for breast and cervical cancer.

  In 2005, the American Indian Screening Initiative Phase II was established. Continuing with the mission of MAIWHC a variety of methods were used to implement the AISI Phase II including one to one relationships with American Indian women on the reservations and in urban areas, the MAIWHC and American Indian subcontracts through the regional contractors. Also as part of the AISI, the MCCP established a Memorandum of Understanding with the Billings area Indian Health Service, the Salish and Kootenai Tribes and the Chippewa and Cree Tribes to provide breast and cervical cancer screening to American Indian women and colorectal cancer screening for American Indian men and women.

  Nearly half of Montana's American Indian population lives on one of seven reservations, which lie in frontier counties. This geographical isolation is a specific barrier for American Indian men and women and is addressed in the MCCP's American Indian Screening Initiative. AISI phase III will be implemented in 2010 to include broader cancer focus and initiatives to reach American Indian men and women. The MAIWHC will have stronger representation on the MTCCC to assist in educating and screening American Indian people in Montana.

C. Cancer Surveillance and Epidemiology Program

The Cancer Surveillance and Epidemiology Program (CSEP) use data from the Montana Central Tumor Registry, the Montana Office of Vital Statistics and other sources to monitor trends in cancer incidence and mortality. The Program publishes Quarterly Surveillance Reports, annual Tumor Registry Reports and reports on special topics.

In addition, the CSEP responds to inquiries from public health officials and private citizens about cancer concerns. The Montana Department of Public Health and Human Services has a Cluster Investigation Team and protocol in place to respond to inquiries about cancer throughout the state.

The Montana Central Tumor Registry (MCTR) has been collecting data continuously since 1979. The MCTR is the primary source of cancer statistics (incidence, trends and survival) in Montana. The data from the MCTR is disseminated in an annual report form. The data that are collected and managed by the MCTR are the primary source of information regarding cancer incidence in Montana. The MCTR maintains a data-management system on the diagnosis, treatment and outcome of cancer and other reportable tumors in Montana.

The primary objective of the MCTR is to analyze the incidence, mortality, survival and the changing frequency of cancer in Montana residents.

Follow-up is conducted yearly on patients registered on the MCTR and is a necessary part of adequate care for cancer patients. All data concerning cancer patients are held in strict confidence by the MCTR.

2 SCREENING SERVICES

A. Enrollment and Screening Duties:

1. Medical Service Provider Enrollment

Cancer control specialists will:

- Solicit and enroll all interested medical service providers in their geographic areas.
- Act as a liaison between the MCCP and the enrolled medical service providers in their geographic areas.
- Be responsible for answering providers' questions about client and program issues.
- Conduct an orientation for enrolled medical service providers.
- Submit a signed and completed provider enrollment packet to the address noted on the provider enrollment application.
- Ensure providers follow the Centers for Disease Control and Prevention (CDC) guidelines for comprehensive cancer screening.
- Ensure providers provide referral to the Montana Breast and Cervical Cancer Treatment Program (MBCCTP) if necessary.

2. Client Enrollment

Cancer control specialists will:

- Determine whether a person is eligible for services, either by telephone or an in-person interview and which screening service they need.
- Complete MCCP enrollment forms, ensuring the following:
  - Each client signs an "Informed consent and Authorization to Disclose Health Care Information". This form must be signed before any services can be provided.
  - Client screening history and risk assessment is completed.

3. American Indian Enrollment

Together with subcontractors, local grassroots coalitions and the statewide Montana American Indian Women's Health Coalition (MAIWHC), cancer control specialists work to increase the number of American Indian individuals being screened through the MCCP per the American Indian Screening Initiative (AISI).

B. Tracking and Follow-up

1. Screening through Diagnosis

The cancer control specialists and enrolled medical service providers share equal responsibility for tracking and follow-up to ensure all clients complete the required diagnostic exams as scheduled.

The cancer control specialist must:

- Implement a referral, tracking and follow-up system covering and documenting a client's initial screening through diagnosis and, if necessary, to initiation of treatment.
- Ensure all clients complete the required diagnostic exams as scheduled and within the required timeframes.
- Notify a client of test results either by telephone, office visit or mail.
  - Do not use any means of communication that cannot ensure confidentiality.
  - Do not send test results to the client by postcard or fax, and do not leave results on an answering machine.

2. Abnormal Results

Tracking and follow-up requirements for abnormal screening and diagnostic results include:

- Contact the client to discuss the type of follow-up needed or schedule an appointment, and inform the client of:
  - The nature of the suspected disease.
  - The need for further testing or follow-up care.
  - The choices (if available) of referrals for definitive diagnostic procedures after screening procedures have been performed.
  - Their responsibility to obtain follow-up care.
- Indicate on the MCCP screening form that a workup is planned and complete the abnormal screening form.
- Supply any other information requested by the MCCP state office on clients with abnormal test results.
- Document contact with the client's enrolled medical service provider in the client's record.

3. Rescreening

Cancer control specialists will notify the client when rescreening is needed. Normal rescreening will occur based on MCCP guidelines and enrolled medical service provider recommendations.

4. Clients "Lost to follow-up"

Before considering a client "lost to follow-up" the cancer control specialist must:

- Make three attempts to contact a client. The first two attempts may be by phone or writing. The third or final attempt must be a letter sent by certified mail with a return receipt requested.
- Complete all attempts to contact a client within 6 weeks of receiving notice of abnormal results.
- Indicate on the MCCP data collection forms "lost to follow-up" under "Status of Final Diagnosis" or "Status of Treatment" when a client does not respond to contact attempts regarding the need for further diagnostic tests, initiation of treatment or when a client dies or moves before workup is started.

5. Client Refusal of Follow-up Tests or Treatment

If a client with an abnormal test result (suspicious for cancer) refuses diagnostic tests or treatment, the "MCCP Acknowledgement of Refusal to Consent to Diagnostic Tests or Treatment" form must be completed by the medical service provider and signed by the client. Cancer control specialists will act as a liaison to the client and provider if necessary.

Indicate on the MCCP data collection forms "Refused" under "Status of Final Diagnosis" or "Status of Treatment" when a client refuses to obtain further diagnostic tests, treatment or severs her relationship with the MCCP.

C. Clients Who Move

1. Within Montana or Out-of-State

When a client moves, the cancer control specialist will refer the client to the Montana regional contractor or the out-of-state program nearest their new residence. It is the client's responsibility to contact the new site for subsequent services, if needed, and to sign a copy of the "Informed Consent and Authorization to Disclose Health Care Information" form for release of medical information.

The cancer control specialist must:

- Notify the MCCP state office that the client has moved.
- Provide the client with copies of the screening results or obtain the client's permission in writing to forward screening results as indicated by the client's request.

D. Patient Navigation

Patient navigation is the component of the MCCP which establishes brokers and maintains the system of clinical services (screening, diagnostic and treatment) and support services to clients.

The specific goal of patient navigation is to ensure MCCP clients receive timely and appropriate rescreening, diagnostic and treatment services. The priority population includes clients who have an abnormal screening test result or a diagnosis of cancer.

Key elements of patient navigation for the MCCP at all levels include:

- Assessment
- Planning
- Coordination
- Monitoring
- Evaluation
- Resource Development

The cancer control specialist is responsible for assessing the client's need for patient navigation services and, if necessary, developing and monitoring each client's plan for these services.

Cancer control specialists will:

- Contact the client to assess for patient navigation services within ten (10) working days of receiving the client's abnormal screening test result.
- Implement the "Patient Navigation Service Agreement Plan" within twenty (20) working days of assessing the client's need for patient navigation services, if needed.
- Refer clients diagnosed with breast or cervical cancer or pre-cancer to the Montana Breast and Cervical Cancer Treatment Program (MBCCTP).
- Monitor and update the Patient Navigation Service Agreement Plan weekly until date of final diagnosis or application for the MBCCTP is made and treatment is initiated.
- Develop a list of available community resources in their multi-county areas.
- Develop formal and informal agreement with other entities in their multi-county areas to facilitate referrals for diagnostic and treatment services.

Patient Navigator Qualifications

The qualifications for patient navigators include (but are not limited to):

- Positive relationship-building skills
- Effective oral and written communication skills
- Demonstrated ability to effect change
- Strong analytic skills
- Effective planning and organizational skills
- Ability to promote client and family autonomy
- Knowledge of funding resources and services
- Knowledge of clinical standards and outcomes

E. Policy and Protocol to Determine Place of Enrollment

The client's county of residence determines the contracting region where he/she will be enrolled with the exception of American Indian clients who live on or near Montana reservations. American Indian men and women's county of residence the region that has direct responsibility for serving the reservation.

F. MCCP Support to Cancer Control Specialists

1. Quality Assurance

- Implement policies and systematic procedures designed to monitor and improve the MCCP.
  - Identify corrective actions to be taken to remedy any problems found in the quality of care provided to the MCCP target population.
- Ensure enrolled medical providers maintain a valid license to practice in Montana.
  - Mammography facilities must be fully certified by the Food and Drug Administration under the Mammography Quality Standards Act of 1992 (MQSA).
  - Cytology facilities must be fully certified by the Food and Drug Administration under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).
- Review client screening data to monitor compliance with the MCCP eligibility guidelines.
- Review patient navigation data for compliance to timeliness and resources used.

2. Reimbursement

The MCCP will:

- Reimburse enrolled medical service providers for the cost of performing covered services, provided these have been conducted in accordance with the algorithms approved by the MCCP. Clients are responsible for paying for any other services or tests.
- Reimburse all approved medical service providers for allowable claims according to the current approved fee schedule, within the time frames and under the guidelines outlined in the MCCP PPM (chapter 3).
- Ensure that Montana Medical Billing on behalf of the MCCP, will:
  - Receive all medical service provider enrollment packets and ensure all federal and state requirements are met for each provider.
  - Ensure medical service providers meet all insurance, licensure and certification requirements for program services as outlined in the MCCP PPM.
  - Receive and adjudicate all claims and reimbursement data, including review for third party payment, duplication, client eligibility and allowable services.

Note: The MCCP is the payer of last resort except for Indian Health Service. The MCCP will provide reimbursement for covered services only if no other source of payment is available to the client. Other available sources of payment include:

- Private insurance (whole or partial payment)
- Medicare
- Medicaid
- Title X Family Planning
- Other local private or public funded programs

This means reimbursement for screening services provided to men and women enrolled in Medicare Part B should be paid by Medicare, not by the MCCP. Medicare Part B is an optional program charging a monthly premium for enrollment. A person who cannot pay the premium to enroll in Medicare Part B and meets the MCCP income eligibility criteria is eligible to receive MCCP services.

3. Training and Communication

MCCP will:

- Provide training, technical assistance and consultation necessary for the performance of services, including support from MCCP consultants on comprehensive cancer control, community collaboration, public outreach and medical service professional education and support.
- Be readily accessible to the Contractor to discuss program issues.
- Provide electronic access to regular reports to the Contractor, which includes a list of MCCP clients screened in the multi-county area and the status of clinical data as required in the MCCP PPM for these clients.
- Provide a toll-free fax line with which the Contractor may communicate with the program.
- Provide data collection forms, provider enrollment packets, MCCP PPMs updates, program brochures and education materials via www.cancer.mt.gov to the Contractor.
- Provide telephone and web meetings related to MCCP operations.
- Provide electronic access to the MCCP site data system as applicable for site entry of data collection forms.

MONTANA CANCER CONTROL PROGRAMS

Breast and Cervical Eligibility and Enrollment Form

MONTANA Department of Public Health & Human Services

Eligibility Information

What is your age?	Do you have Medicare Part B? ☐ Yes ☐ No	Do you have Medicaid? ☐ Yes ☐ No
Family's yearly income before taxes	Do you have health insurance that Might cover these services? ☐ Yes ☐ No	
Number of people in household	Insurance Company	

Enrollment Information

Last Name	First Name	Middle Initial	Other Last Names Used
Date of Birth MM / DD / YYYY	Social Security Number	State	County
Mailing Address	Street Address		City
Home/Cell Phone	Work/Message Phone		Zip

Ethnic Background

Are you Hispanic? (Spanish/ Hispanic / Latino)

☐ Yes ☐ No ☐ Unknown

Race: Check all races that apply.

- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Unknown

Medical Background

Are you having any breast problems? ☐ Yes ☐ No

Do you have breast implants? ☐ Yes ☐ No

Have you ever had a mammogram? ☐ Yes ☐ No

Date of last mammogram _____ MM / DD / YYYY

Have you ever had a Pap test? ☐ Yes ☐ No

Date of last Pap _____ MM / DD / YYYY

Have you ever had a hysterectomy? ☐ Yes ☐ No

Do you use tobacco? No ☐ Yes ☐ **If Yes, refer the client to the MT Quit Line. 1-800-QUIT-NOW**

How did you hear about the program? Please check all that apply.

☐ Radio	☐ Presentation	☐ Pink/Purple Card (Pamphlet)	☐ Special Promotion/Event/Ad
☐ TV	☐ Medical Provider	☐ Government Office	☐ Newspaper/Newsletter
☐ Internet	☐ MAIWHC	☐ Re-screen/Previously Enrolled	☐ Fair-Job/Health or Pow Wow
☐ Family/Friend/Word of Mouth		☐ _____	

PLEASE READ AND SIGN THE

INFORMED CONSENT AND AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION

Office Use Only Fiscal Yr _____ Admin Site # _____ State ID _____

Form(s) submitted ☐ **New Screening Cycle** ☐ **Re-submitted with revisions**

Eligibility determined by (please print)_____ Date MM / DD / YYYY

Client under age - prior approval given by_____ Date MM / DD / YYYY

☐ Client under age (18-29) - meets criteria

MONTANA CANCER CONTROL PROGRAMS

Please Read and Sign

MONTANA Department of Public Health & Human Services

Client Name:	**Social Security Number:**

Informed Consent and Authorization to Disclose Health Care Information

The Montana Cancer Control Programs (MCCP) receives funds from the Center for Disease Control and Prevention (CDC) to provide cancer screening for age and income eligible Montana residents. Montana men and women can be screened through this program for colorectal cancer and women can also receive breast and cervical cancer screenings. Each time a client is screened for colorectal cancer, they may receive either an FOBT/FIT test or a colonoscopy. If any of the initial tests for colorectal cancer are abnormal, further diagnostic testing may be required, which may include a diagnostic colonoscopy and/or biopsy of colon tissue. Each time a client is screened for breast cancer, they may receive a clinical breast exam and breast X-ray called a mammogram. For cervical cancer, a client may receive a pelvic examination and a Pap test. If any of the initial tests for breast and cervical cancer are abnormal, further diagnostic testing may be required, which may include a diagnostic mammogram, ultrasound, and/or biopsy of the breast or cervical tissue. MCCP will provide patient navigation services that will help you complete all the diagnostic tests and find resources that may help for treatment (if necessary). By enrolling in the MCCP you are accepting responsibility for keeping appointments and completing all the screening and diagnostic tests that are recommended by your medical provider.

Services Not Covered

The MCCP only provides services for colorectal, breast and cervical cancer screening and limited diagnostic tests. The program does not cover services for other health conditions, some diagnostic services, or cancer treatment. If I need services that are not covered, the MCCP staff will refer me to agencies that may help provide treatment. I understand that I may be billed for services not covered by the MCCP.

Insurance Information

I understand I have met the eligibility guidelines for the MCCP. I may have insurance coverage and still be eligible to participate. However, my insurance will be billed first for cancer screening services. If the services are not fully reimbursed by my insurance, the MCCP will pay the unpaid balance up to the maximum allowable Medicare reimbursement rate.

Confidentiality

Any information provided by me will remain confidential, which means that the information will be available only to me, my health care provider, and to the MCCP staff. The MCCP staff means those personnel and the Montana Department of Public Health and Human Services, administrative site and the tribal organizations and Indian Health Service Units who are specifically designated to work in the MCCP. Program reports will include information on groups of clients and will not identify any client by name or tribal affiliation.

Authorization to Disclose Health Care Information

I consent to and authorize the mutual exchange of screening and diagnostic records among the MCCP staff, my health care provider(s), the laboratory reading my FIT and/or Pap smear, and the radiology facility where my mammogram is performed with respect to MCCP related services received by me up to six months after the date indicated below. This authorization expires thirty months after the date I signed below.

I have read the information provided herein, discussed this and other information about the MCCP and agree to participate in the program. I have had an opportunity to ask question about the MCCP and have received answers to any question I had. All information, including financial and insurance benefits, I have provided to the MCCP is, to the best of my knowledge, true. I understand that my participation is voluntary and that I may drop out the MCCP at any time.

Client Signature: _____	**Date:** _____ MM / DD / YYYY
Print Full Name: _____	

MONTANA CANCER CONTROL PROGRAMS

Breast and Cervical Screening Form

MONTANA Department of Public Health & Human Services

Client Name	Phone Number	State ID	
Social Security Number - -	Date of Birth MM / DD / YYYY	Admin Site #	☐ Revised

CERVICAL CANCER SCREEN RESULTS

Date of Pap test MM / DD / YYYY

Pap specimen type ☐ Liquid ☐ Conventional

Adequacy of Pap specimen ☐ Satisfactory ☐ Unsatisfactory

Result of screening Pap test
- ☐ Negative for intraepithelial lesion or malignancy
- ☐ ASC-US
- ☐ Low Grade SIL (including HPV changes)
- ☐ **ASC-H**
- ☐ **High Grade SIL**
- ☐ **Squamous Cell Carcinoma**
- ☐ **Abnormal Glandular Cells**

Date of HPV/DNA test MM / DD / YYYY

High Risk HPV/DNA test results if done

☐ **Positive** ☐ Negative

Paid by MCSP Pap test ☐ Yes ☐ No
HPV/DNA test ☐ Yes ☐ No

Reason for Pap test
- ☐ Routine screening
- ☐ Surveillance, follow-up of previous abnormal
- ☐ Done outside the MCSP, diagnostics only
- ☐ Not done, diagnostics only
- ☐ Breast record only

Date referred to the MCSP for diagnostic workup

Date referred MM / DD / YYYY

Additional procedures
- ☐ Not planned, normal follow-up
- ☐ Planned, further diagnostic tests needed

Next Pap test or follow-up due MM / DD / YYYY

Recommendations/comments _____

_____

Provider's signature _____

Print provider's name _____

Respond for ALL clients screened for cervical cancer

Has this client had a hysterectomy? ☐ Yes ☐ No

If "Yes" was the hysterectomy
Due to cervical neoplasia? ☐ Yes ☐ No

Is the cervix still present? ☐ Yes ☐ No

A client who has had a hysterectomy is eligible for an MCSP Pap test if the hysterectomy was due to cervical neoplasia or the cervix is present.

Respond for clients with a NORMAL Pap test result

Recommend the cervical cancer screening interval for this client.
- ☐ Short term follow-up, abnormal protocol
- ☐ Annual, conventional Pap test
- ☐ Every 2 years, liquid based cytology
- ☐ Every 3 years, 3 normal Pap tests within 60 months

BREAST CANCER SCREEN RESULTS

Date of Clinical Breast Exam MM / DD / YYYY

Clinical Breast Exam (CBE) findings
- ☐ Normal exam
- ☐ Benign findings
- ☐ **Abnormal, suspicious for cancer**
- ☐ CBE not done

Date of Mammogram MM / DD / YYYY

Mammogram type ☐ **Digital** ☐ **Conventional**

Mammography test results - BI-RAD Categories
- ☐ Negative: Category 1
- ☐ Benign: Category 2
- ☐ Probably benign short interval follow-up suggested: Category 3
- ☐ **Suspicious Abnormality: Category 4**
- ☐ **Highly suggestive of malignancy: Category 5**
- ☐ **Assessment Incomplete: Category 0**

Paid by the MCSP CBE ☐ Yes ☐ No
Mammogram ☐ Yes ☐ No

Reason for Mammography test
- ☐ Routine screening
- ☐ Evaluate symptoms, positive CBE/prev abnormal mammogram
- ☐ Done outside the MCSP, diagnostics only
- ☐ Not done only received CBE or diagnostics
- ☐ Cervical record only

Date referred to the MCSP for diagnostic workup

Date referred MM / DD / YYYY

Additional procedures
- ☐ Not planned, normal follow-up
- ☐ Planned, further diagnostic tests needed

Next breast screening or follow-up due MM / DD / YYYY

Recommendations/comments _____

_____

Provider's signature _____

Print provider's name _____

MONTANA CANCER CONTROL PROGRAMS

Breast and Cervical Abnormal Form

MONTANA
Department of Public Health & Human Services

Client Name	Phone Number	State ID	
Social Security Number - -	Date of Birth MM / DD / YYYY	Admin Site #	☐ Revised

Additional Procedures	Date	Results	☐ Diagnostics Paid by MCSP
Imaging Procedures		**Result of imaging procedure**	
Additional mammographic views	____/____/_____	☐ Done _____	
Ultrasound	____/____/_____	☐ Done _____	
Film comparison (to evaluate assessment incomplete)	____/____/_____	☐ Done _____	
Final imaging outcome (Includes all imaging procedures and film comparisons done.)	____/____/_____	☐ Negative (1) ☐ Benign (2) ☐ Probably Benign (3) ☐ Suspicious Abnormality (4) ☐ Highly suggestive of malignancy (5)	
Surgical consult, repeat breast exam	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	
Fine needle biopsy/cyst aspiration	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	
Incisional biopsy	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	
Excisional biopsy	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	
Colposcopy directed biopsy/ECC	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	
Diagnostic LEEP	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	
Diagnostic cold knife cone	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	
Diagnostic endocervical curettage	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	
Gyn consult	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	
Other - list: _____	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	

Breast Final Diagnosis

☐ Cancer not diagnosed

☐ Cancer, in-situ - LCIS

☐ **Cancer, in-situ - DCIS**

☐ **Cancer, invasive**

Cervical Final Diagnosis

☐ Normal/benign/inflammation

☐ HPV/condylomata/Atypia

☐ Mild dysplasia/CIN I (bx dx)

☐ Low grade SIL (bx dx)

☐ **Moderate dysplasia/CIN II** (bx dx)

☐ **High grade SIL** (bx dx)

☐ **Severe dysplasia/CIN III/Carcinoma in situ** (bx dx)

☐ **Invasive cervical carcinoma** (bx dx)

☐ Other - List: _____

Complete for Breast and /or Cervical Findings

Status of final diagnosis/imaging: (**date is required)**

☐ Workup complete Date _____/_____/_____

☐ Workup refused Date _____/_____/_____

☐ Lost to follow-up Date _____/_____/_____

Comments _____

_____

Status of treatment: (**required for bolded final diagnoses)**

☐ Started Date _____/_____/_____

☐ Refused Date _____/_____/_____

☐ Lost to follow-up Date _____/_____/_____

Next screening or follow-up due _____/_____
Month Year

Provider's signature _____

Print provider's name _____

MONTANA CANCER CONTROL PROGRAMS

Colorectal Eligibility & Enrollment Form

MONTANA Department of Public Health & Human Services

Last Name	First Name	Middle Initial	Other Last Names Used (*If Applicable*)

Birth Date MM / DD / YYYY	Age	Gender ☐ Male ☐ Female	Social Security Number - -	State	County

Mailing Address	City	Zip

Annual Family Income before Taxes	Number of People in Household	Home/Cell Phone	Work Phone

Do you have Medicare Part B?	Do you have Medicaid?	Do you have health insurance?	Name of Insurance Company
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Ethnic Background Are you Hispanic? *(Spanish/ Hispanic / Latino)*
☐ Yes ☐ No ☐ Unknown

Race: *Check all races that apply.*
☐ White ☐ American Indian or Alaska Native
☐ Asian ☐ Native Hawaiian /Other Pacific Islander
☐ Unknown ☐ Black/African American

How did you hear about the program? *Please check all that apply.*
☐ Doctor ☐ Other Health Care Provider ☐ Friend
☐ Newspaper ☐ NBCCEDP/Colorectal Program ☐ TV
☐ Mailing Flyer ☐ Magazine Article ☐ Radio
☐ Family Member ☐ Community Event
☐ Other _____

********** **To Be Completed By The Client With The Assistance of The Screening Specialist** **********

Do you use tobacco? **No** ☐ **Yes** ☐ **If Yes, refer the client to the MT Quit Line. 1-800-QUIT-NOW**

Screening History / Risk Assessment

Colorectal Cancer Screening History:

Have you ever had a colorectal cancer screening test? (FOBT/FIT, Colonoscopy, Sigmoidoscopy, DCBE, CTC, Stool DNA) ☐ Yes ☐ No ☐ Unknown Date: _____

Personal History of Colorectal Cancer:

Have you ever been diagnosed with colorectal cancer? ☐ Yes ☐ No ☐ Unknown
Have you ever been diagnosed with polyps? ☐ Yes ☐ No ☐ Unknown
Have you ever been diagnosed with pre-cancerous polyps or adenomatous polyps? ☐ Yes ☐ No ☐ Unknown

Family History of Colorectal Cancer:

Has a blood relative been diagnosed with colorectal cancer or pre-cancerous polyps / adenomatous polyps? ☐ Yes ☐ No ☐ Unknown

Are you currently experiencing any of the following symptoms?
☐ Yes ☐ No ☐ Unknown

Please check all that apply.
☐ Rectal bleeding, dark stool, blood in the stool within the past 6 months.
☐ Prolonged change in bowel habits: diarrhea/constipation for more than 2 weeks.
☐ Persistent abdominal pain.
☐ Symptoms of bowel obstruction, abdominal distension, nausea, vomiting.
☐ Significant unintentional weight loss of 10% or more of starting body weight.

Have you been diagnosed with or are you being treated for any of the following? ☐ Yes ☐ No ☐ Unknown

Please check all that apply.
☐ A genetic diagnosis of Familial Adenomatous Polyposis (FAP) or Hereditary Non Polyposis Colorectal Cancer (HNPCC)?
☐ A clinical diagnosis or suspicion of FAP or HNPCC?
☐ Inflammatory Bowel Disease (Crohn's Disease or Ulcerative Colitis)?

Did the client sign the Informed Consent Form? ☐ Yes ☐ No ***Office Use Only***

Admin Site # _____ **State ID** _____

Eligibility Determined By: _____ **Date Eligible** _____

MONTANA CANCER CONTROL PROGRAMS

Please Read and Sign

MONTANA Department of Public Health & Human Services

Client Name:	**Social Security Number:**

Informed Consent and Authorization to Disclose Health Care Information

The Montana Cancer Control Programs (MCCP) receives funds from the Center for Disease Control and Prevention (CDC) to provide cancer screening for age and income eligible Montana residents. Montana men and women can be screened through this program for colorectal cancer and women can also receive breast and cervical cancer screenings. Each time a client is screened for colorectal cancer, they may receive either an FOBT/FIT test or a colonoscopy. If any of the initial tests for colorectal cancer are abnormal, further diagnostic testing may be required, which may include a diagnostic colonoscopy and/or biopsy of colon tissue. Each time a client is screened for breast cancer, they may receive a clinical breast exam and breast X-ray called a mammogram. For cervical cancer, a client may receive a pelvic examination and a Pap test. If any of the initial tests for breast and cervical cancer are abnormal, further diagnostic testing may be required, which may include a diagnostic mammogram, ultrasound, and/or biopsy of the breast or cervical tissue. MCCP will provide patient navigation services that will help you complete all the diagnostic tests and find resources that may help for treatment (if necessary). By enrolling in the MCCP you are accepting responsibility for keeping appointments and completing all the screening and diagnostic tests that are recommended by your medical provider.

Services Not Covered

The MCCP only provides services for colorectal, breast and cervical cancer screening and limited diagnostic tests. The program does not cover services for other health conditions, some diagnostic services, or cancer treatment. If I need services that are not covered, the MCCP staff will refer me to agencies that may help provide treatment. I understand that I may be billed for services not covered by the MCCP.

Insurance Information

I understand I have met the eligibility guidelines for the MCCP. I may have insurance coverage and still be eligible to participate. However, my insurance will be billed first for cancer screening services. If the services are not fully reimbursed by my insurance, the MCCP will pay the unpaid balance up to the maximum allowable Medicare reimbursement rate.

Confidentiality

Any information provided by me will remain confidential, which means that the information will be available only to me, my health care provider, and to the MCCP staff. The MCCP staff means those personnel and the Montana Department of Public Health and Human Services, administrative site and the tribal organizations and Indian Health Service Units who are specifically designated to work in the MCCP. Program reports will include information on groups of clients and will not identify any client by name or tribal affiliation.

Authorization to Disclose Health Care Information

I consent to and authorize the mutual exchange of screening and diagnostic records among the MCCP staff, my health care provider(s), the laboratory reading my FIT and/or Pap smear, and the radiology facility where my mammogram is performed with respect to MCCP related services received by me up to six months after the date indicated below. This authorization expires thirty months after the date I signed below.

I have read the information provided herein, discussed this and other information about the MCCP and agree to participate in the program. I have had an opportunity to ask question about the MCCP and have received answers to any question I had. All information, including financial and insurance benefits, I have provided to the MCCP is, to the best of my knowledge, true. I understand that my participation is voluntary and that I may drop out the MCCP at any time.

Client Signature: _____	**Date:** _____ MM / DD / YYYY
Print Full Name: _____	

MONTANA CANCER CONTROL PROGRAMS

Colorectal Screening Form

MONTANA Department of Public Health & Human Services

Last Name	First Name	Middle Initial	Birth Date	Admin Site #
			MM / DD / YYYY	

Social Security Number	Phone Number	State ID
- -		

Date initial test scheduled or fecal kit distributed
Date MM / DD / YYYY

Screening adherence
☐ Not done, FOBT/FIT kit not returned ☐ Not done, appointment not kept.

Take Home Test :
☐ FOBT ☐ FIT

Date of result MM / DD / YYYY

Indication for test
☐ Screening

Result
☐ Negative
☐ Positive
☐ Pending
☐ Unknown

Outcome
☐ Complete
☐ Incomplete/Inadequate
If Incomplete/inadequate, reason: _____

Take Home Test FOBT or FIT Section

Provider specialty
☐ General Practitioner ☐ Internist ☐ Family Practitioner
☐ Gastroenterologist ☐ General Surgeon ☐ Radiologist
☐ Colorectal Surgeon ☐ Physician Assistant ☐ OB/Gyn
☐ Registered Nurse ☐ Licensed Practical Nurse ☐ Nurse Practitioner

Next test recommended in this cycle
☐ Colonoscopy ☐ Sigmoidoscopy
☐ DCBE ☐ Surgery to complete diagnosis
☐ None, cycle complete ☐ Other _____

Procedure Performed:
☐ Colonoscopy ☐ DCBE

Procedure Date MM / DD / YYYY

Indication for test
☐ Screening ☐ Surveillance ☐ Diagnostic

Result
☐ Normal/negative/diverticulitis/hemorrhoids
☐ Other findings, not suggestive of cancer/polyps
☐ Polyps/suspicious for cancer/presumed cancer
☐ Inadequate/Incomplete test with no findings
☐ Pending

Outcome
☐ Complete ☐ Incomplete/Inadequate

Was a biopsy/polypectomy performed during the endoscopy? ☐ Yes ☐ No
If Yes, complete the Colorectal Endoscopy Section II Form.

Endoscopy Section I

Provider specialty
☐ General Practitioner ☐ Internist ☐ Family Practitioner
☐ Gastroenterologist ☐ General Surgeon ☐ Radiologist
☐ Colorectal Surgeon ☐ Physician Assistant ☐ OB/Gyn
☐ Registered Nurse ☐ Licensed Practical Nurse ☐ Nurse Practitioner

Adequate bowel preparation to detect polyps greater than 5mm. (decided by the endoscopist) ☐ Yes ☐ No ☐ Unknown

Was the cecum reached during this colonoscopy?
☐ Yes ☐ No ☐ Unknown
If No, was the splenic flexure reached? ☐ Yes ☐ No

Were there any complications? ☐ Yes ☐ No
If Yes, complete the Colorectal Endoscopy Section II Form.

Next test recommended in this cycle
☐ Colonoscopy ☐Sigmoidoscopy
☐ DCBE ☐ Surgery to complete diagnosis
☐ None, cycle complete ☐ Other _____

Status of Final Diagnosis
☐ Complete
☐ Pending
☐ Refused diagnostic follow-up
☐ Lost to follow-up before final diagnosis

Date of final diagnosis, refused, or lost to follow up
MM / DD / YYYY

Final Diagnosis
☐ Normal/Negative
☐ Hyperplastic polyps
☐ Adenomatous polyp, no high grade dysplasia
☐ Adenomatous polyp, with high grade dysplasia
☐ Cancer

Recurrent Cancers
☐ New colorectal cancer, primary
☐ Recurrent colorectal cancer
☐ Non colorectal cancer primary (metastasis from another organ)
☐ Unknown

Recommended screening or surveillance test for next cycle
☐ Take home FOBT ☐ Take home FIT
☐ Colonoscopy ☐ Sigmoidoscopy
☐ DCBE ☐ None

Number of months before screening or surveillance test for next cycle.
(If none, leave blank) _____

Indication for screening or surveillance test for next cycle
☐ Screening ☐ Surveillance after a positive colonoscopy and/or surgery

If client has a polypectomy, biopsy, surgery or complications, complete the Colorectal Endoscopy Section II Form.

Provider Signature _____ **Provider Name** _____

MONTANA CANCER CONTROL PROGRAMS

Colorectal Endoscopy Section II Form

MONTANA Department of Public Health & Human Services

Last Name	First Name	Middle Initial	Birth Date	Admin Site #
			MM / DD / YYYY	

Social Security Number	Phone Number	State ID
- -		

Histology of most severe polyp/lesion
(*Complete if biopsy/polypectomy was done during the colonoscopy)*
- ☐ Normal or other non-polyp histology
- ☐ Non-adenomatous polyp (inflammatory, hamartomatous, etc.)
- ☐ Hyperplastic polyp
- ☐ Adenoma, NOS (no high grade dysplasia noted)
- ☐ Adenoma, tubular (no high grade dysplasia noted)
- ☐ Adenoma, mixed tubular villous (no high grade dysplasia noted)
- ☐ Adenoma, villous (no high grade dysplasia noted))
- ☐ Adenoma, serrated (no high grade dysplasia noted)
- ☐ Adenoma with high grade dysplasia (includes in situ carcinoma)
- ☐ Adenocarcinoma, invasive
- ☐ Cancer, other
- ☐ Unknown/other lesions ablated, not retrieved or confirmed

Number of adenomatous polyps/lesions
(Complete if result of the histology is Adenoma or Cancer)
- ☐ Less than 97…..Enter the number _____
- ☐ 97 or more adenomatous polyps/lesions
- ☐ At least one adenomatous polyps/lesions, exact number not known
- ☐ Unknown

Size of largest adenomatous polyp/lesion
(Complete if result of the histology is Adenoma or Cancer)
- ☐ Less than 1 cm……. Enter the size _____
- ☐ Greater than 1 cm …Enter the size _____
- ☐ Between 1 cm and 2 cm ☐ Between 2 cm and 3 cm
- ☐ Between 3 cm and 4 cm ☐ Between 4 cm and 5 cm
- ☐ Microscopic focus ☐ Diffuse
- ☐ Unknown (size not stated)

Histology from surgical resection
(*Complete if surgery was performed to complete diagnosis.)*
- ☐ Surgery recommended but not performed
- ☐ Normal or other non-polyp histology
- ☐ Non-adenomatous polyp (inflammatory, hamartomatous, etc.)
- ☐ Hyperplastic polyp
- ☐ Adenoma, NOS (no high grade dysplasia noted)
- ☐ Adenoma, tubular (no high grade dysplasia noted)
- ☐ Adenoma, mixed tubular villous (no high grade dysplasia noted)
- ☐ Adenoma, villous (no high grade dysplasia noted))
- ☐ Adenoma, serrated (no high grade dysplasia noted)
- ☐ Adenoma with high grade dysplasia (includes in situ carcinoma)
- ☐ Adenocarcinoma, invasive
- ☐ Cancer, other
- ☐ Unknown/other lesions ablated, not retrieved or confirmed

Date surgery performed MM / DD / YYYY

Complications of endoscopy requiring observation or treatment.
(*Report the worst of up to 2 serious complications of CRC testing occurring within 30 days of the test date and resulting in an ER visit or hospitalization.)*
- ☐ No complications
- ☐ Bleeding, transfusion required
- ☐ Bleeding not requiring transfusion
- ☐ Cardiopulmonary events (hypotension, hypoxia, arrhythmia, etc)
- ☐ Complications related to anesthesia
- ☐ Bowel perforation
- ☐ Post-polypectomy syndrome/excessive abdominal pain
- ☐ Death
- ☐ Other _____

Print Provider's Name _____

Provider's Signature _____

Status of treatment (Complete if final diagnosis is Cancer)
- ☐ Started and/or completed
- ☐ Not indicated due to polypectomy
- ☐ Not recommended
- ☐ Refused
- ☐ Lost to follow-up
- ☐ Treatment pending

Date of treatment MM / DD / YYYY

MONTANA
Department of Public Health & Human Services

MONTANA CANCER CONTROL PROGRAMS

PATIENT NAVIGATION SERVICE AGREEMENT PLAN

Date Initiated _____ **Regional Site** _____
Patient Navigator _____

Last Name:	**First Name:**	**Social Security Number:**

BREAST FOLLOW-UP

Procedure Scheduled < 60 days of abnormal finding	**Provider Name**	**Appointment Date**	**Appointment Re-Scheduled**	**Results**	**Completion Date/Initial**
☐ **Diagnostic Mammogram**					
☐ **Breast Ultrasound**					
☐ **Surgical Consult/Repeat Breast Exam**					
☐ **Fine Needle Biopsy/Cyst Aspiration**					
☐ **Biopsy**					
☐ **Other (specify):** _____					

CERVICAL FOLLOW-UP

Procedure Scheduled < 60 days of abnormal finding	**Provider Name**	**Appointment Date**	**Appointment Re-Scheduled**	**Results**	**Completion Date/Initial**
☐ **GYN Consult**					
☐ **Colposcopy with Directed Biopsy,ECC**					
☐ **Other (specify):** _____					

Monitoring Dates:
Weekly, until date of final diagnosis or application for Medicaid treatment is made (if needed) and treatment initiated

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Lost to follow-up/Refusal: Contact Attempts

Contact Method	**Date**	**Result**
☐ Telephone	_____	_____
☐ Telephone	_____	_____
☐ Telephone	_____	_____
☐ Letter	_____	_____
☐ Certified Letter	_____	_____

Montana Cancer Control Programs
Acknowledgment of Refusal to Consent to Diagnostic Tests or Treatment

Patient Name (Print):_____

My health care provider has recommended further diagnostic testing/treatment to me. I understand these diagnostic tests will help my health care provider diagnose cancer or the treatment recommended for cancer.

I have read and understand the paragraph(s) below that pertain to my decision to refuse diagnostic tests and/or treatment.

The health care provider named below has explained to me that I need **diagnostic test(s)** to determine if I have breast, cervical, or colorectal cancer (circle one). The test(s) that are recommended to me include:

_____

_____

If the diagnostic test(s) have been completed, I have read and understand the result(s) and the diagnoses that are listed below:

_____

_____

The health care provider named below has explained to me that I need **treatment** for breast, cervical or colorectal cancer (circle one). The treatment recommended to me is:

_____

_____

My health care provider named below has explained to me that the recommended test(s)/treatment are for breast, cervical or colorectal (circle one) cancer and the likely consequences of refusing the test(s) or treatment, if I have cancer are:

_____

_____

I understand that the refusal of the test(s)/ treatment recommended by my health care provider may endanger my health, or could lead to my death. Knowing this, I refuse to consent to such recommended test(s)/treatment.

I hereby release my doctor/health care provider, _____(Print Name) and the Montana Department of Health and Human Services (DPHHS) from any liability or responsibility for not providing the test(s)/treatment described and referred to above.

_____(Date)_____

Patient signature

_____(Date)_____

3 ENROLLED MEDICAL SERVICE PROVIDERS

A. General Description

An enrolled medical service provider's role is to provide direct clinical screening services to MCCP clients and to complete the MCCP data collection forms.

Indian Health Service (IHS) and compacted tribal reservation clinics are enrolled in the program as health care facility/clinic. Cancer control specialists answer provider questions about the program and assist with orienting providers to the program.

B. Medical Service Provider Enrollment

1. Eligibility

The types of medical service providers eligible for enrollment are:

- Any licensed qualified health department
- Community health centers
- Non-profit health centers
- Other health care facilities and clinics
- Individual providers
- Laboratories
- Radiology facilities
- Naturopathic physicians

To be eligible for enrollment, medical service providers must meet all the following criteria:

- Be licensed in the state of Montana
- Have the required insurance
- Meet the certification requirements of the Health Care Financing Administration Clinical Laboratory Improvement Act of 1988 (HCFA CLIA [1988]) and the Food and Drug Administration's Mammography Quality Standards Act of 1992 (FDA's MQSA [1992]), if applicable to the services provided.

2. Enrollment

Cancer control specialists will act as a liaison between the MCCP and the enrolled medical service providers in each multi-county area. All enrolled medical service providers may use the cancer control specialist to address client and program issues.

To enroll in the MCCP, contact the cancer control specialist in the appropriate geographic area or Montana Medical Billing in Helena (Provider Assistance at 1-888-227-7065).

During enrollment, each enrolled medical service provider will be required to:

- Complete and sign a provider enrollment application.
- Submit the necessary certificates and forms with the enrollment packet:
  - Certificate of Assurances: Non-Construction Programs (standard form 424BCRev 7-97)
  - MDPHHS Certificate of Compliance
  - Disclosure of Lobbying Activities (if applicable)
  - W-9
- Attend an orientation session provided by a MCCP cancer control specialist.

C. Scope of Services: Service Requirements

1. General Description

The services for which enrolled medical service providers will be reimbursed include an office visit for the purpose of:

- Client education
- Obtaining a health history
- Determining appropriate referral services
- Performing a risk assessment
- Performing a clinical breast exam
- Performing a bimanual pelvic exam
- Obtaining a specimen for cervical cancer diagnosis
- Providing a means for collection of stool specimen for fecal occult blood testing (FOBT)

Enrolled medical service providers include those who provide consulting services for diagnostic procedures. MCCP defines a consultation as a service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another enrolled medical service provider.

All enrolled medical service providers will refer to the American Medical Association current procedural terminology (CPT) manual, which further defines each service code and the level of responsibility and appropriateness for breast, cervical and colorectal cancer screening and detection.

Medical service providers must be enrolled with the MCCP to provide screening services and receive reimbursement from the MCCP.

2. All Enrolled Medical Service Providers

All enrolled medical service providers agree to:

- Obtain consent from MCCP clients prior to releasing screening results to the MCCP; the consent must meet the requirements of Section 50-16-526, Montana Code Annotated.
- Follow the algorithms, guidelines and conditions outlined in the MCCP Policy and Procedure Manual.

- Attend at least one program orientation provided by the MCCP regarding the breast, cervical and colorectal cancer screening program before providing screening services.
    - Orientation programs will be provided at the enrolled medical service provider's office whenever possible in order to facilitate participation by the enrolled medical service provider and their staff.
- Ensure that all members of their staff who provide MCCP services have current knowledge of the latest breast, cervical and colorectal cancer screening techniques and recommendations.
- Ensure that all delegated services or tasks associated with the performance of their agreement with the MCCP are in accordance with the guidelines outlined in the MCCP Policy and Procedure Manual.
- Provide the MCCP, upon request, information needed to correct, complete or clarify the MCCP data collection forms, reports or claims.
- Provide referral to the MBCCTP if necessary.

3. All Primary Health Care Providers

All primary health care providers must provide the services in Part C-2 above and in addition must:

- Provide an office visit annually or as indicated, including a brief medical history, bimanual pelvic exam, Pap smear (if indicated), clinical breast exam, means for stool collection for FOBT (if indicated) and education on the importance of regular breast, cervical and colorectal cancer screening, in accordance with the MCCP Policy and Procedure Manual.
- Provide referral for a screening mammogram or screening colonoscopy based on guidelines described in the MCCP Policy and Procedure Manual.
- Notify the client of both normal and abnormal screening results within 10 working days after receiving screening results.
- Work with the MCCP cancer control specialist to ensure that all screening participants are notified of the need for rescreening (i.e., mammograms, Pap smears, clinical breast exams, FOBT and colonoscopies) in a timely manner.
- Notify the administrative site within 10 working days after receiving screening results for an MCCP client by forwarding the MCCP data collection forms.
- Ensure that the following diagnostic services are provided to MCCP clients, if indicated by abnormal screening test results:
    - Repeat office visit(s), repeat Pap smear, colposcopy directed biopsy or referral for these services
    - Repeat clinical breast exam, referral for diagnostic mammogram, ultrasound, fine needle aspiration or other diagnostic procedures reimbursed by the MCCP
    - Diagnostic colonoscopy.
- Assist the MCCP cancer control specialist to identify and access resources available for additional diagnosis, follow-up and treatment and make referrals to the MBCCTP for MCCP clients whose clinical findings indicate treatment is needed.

- Report all clinical screening test results to the cancer control specialist on the MCCP data collection forms.
  - The forms must be received within the timelines set by the administrative site.
  - The forms must be complete, accurate and signed by the enrolled medical service provider.
- Ensure that all cytology and/or tissue specimens will be submitted to laboratories that are certified and in compliance with the HCFA's CLIA (1988) and ensure that laboratories report all Pap test results using the current Bethesda System for cervical cancer screening. (In order to determine if a laboratory is CLIA-certified, contact the MDPHHS's Certification Bureau at 406-444-1451.)
- Ensure that all referrals for mammography will be made only to radiology facilities that are fully accredited under the FDA's MQSA (1992).

The enrolled medical service provider must ensure that all mammography results are reported using the second edition of the American College of Radiology (ACR) Breast Imaging and Reporting Data System (BI-RADS), 2nd edition.

4. Radiology Providers

All radiology facility providers must provide the services in Part C-2 above and in addition must:

- Provide the result(s) to the primary care provider or referring medical specialist using the ACR BI-RADS within 10 working days after interpreting and/or receiving the result(s) of the procedures provided for MCCP clients.
- Provide documentation that the facility is currently certified as meeting the provisions of the FDA's MQSA (1992) upon enrollment.

5. Laboratory Service Providers

All laboratory service providers must provide the services in Part C-2 above and in addition must:

- Interpret cytology and/or tissue specimens from MCCP clients that are submitted by MCCP enrolled medical service providers.
- Provide the result(s) using the Bethesda System to the enrolled medical service provider, along with recommendations for further follow-up and/or treatment, within 10 working days.
- Provide documentation that the laboratory is in compliance with the HCFA's CLIA (1988) upon enrollment.

6. Colorectal Screening and Diagnostic Tests

We recommend endoscopists follow the standardized colonoscopy reporting and data system (CO-RADS). [Gastrointest Endosc. 2007 May;65(6):757-66]

7. Consulting Specialists

MCCP defines a consultation as a service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another enrolled medical service provider. All consulting specialists must provide the services in Part C-2 and Part C-3 (with the exception of C-3.b) above and in addition must:

- Notify the client's primary care provider of test result(s), along with recommendations for further follow-up and/or treatment, within 10 working days after interpreting and/or receiving the results.
- Notify the MCCP cancer control specialist of the above result(s) on the MCCP data collection forms for abnormal breast and/or cervical screening results or notify the client's primary health care provider of the result(s). The primary health care provider will then record the result(s) on the MCCP data collection forms.

8. Anesthesiology Specialists

All anesthesiology specialists must provide the MCCP, upon request, information needed to correct, complete or clarify the MCCP claims.

9. Surgical Facilities

All surgical facilities must provide the services in Part C-2 above.

D. Record Maintenance and Retention

1. Record Maintenance

Enrolled medical service providers must establish a medical file[1] for every MCCP client. Each file must:

- Include a signed and dated "Informed Consent and Authorization to Disclose Health Care Information" and must be maintained in accordance with accepted medical standards.
- Contain medical entries that are each signed and dated by the clinician making the entry and that include the clinician's title.
- Be treated as confidential, secured by lock when not in use and in all respects safeguarded against loss or use by unauthorized persons.
- Be shared freely with the medical service provider who accepts a referral for additional diagnostic tests.
- Be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) regulations, if applicable.

[1] The term "medical file" refers to records kept in the enrolled medical service provider's office. "Client record" refers to the MBCHP data collection forms and supporting documentation.

2. Record Retention

To comply with MCCP record retention and audit requirements, all enrolled medical service providers must:

- Retain all records, documents and correspondence relative to an MCCP client for a period of not less than 5 years from the date of the last entry made in the client's medical file.
- Retain all financial records, supporting documents, statistical records and other pertinent records for a period of 3 years or until an audit has been completed and questions resolved, whichever is later.
- Participate in reviews and audits of the records and documents related to MCCP clients, which may be conducted at any reasonable time by state personnel or other persons duly authorized by the MDPHHS. The reviews may include:
  - Meetings with consumers
  - Review of medical records
  - Review of policies and procedures
  - Meetings with any staff directly or indirectly involved in the provision of services

E. Claims and Reimbursement

1. General Requirements

In order to receive payment for providing comprehensive screening services to MCCP clients, a medical service provider must:

- Be enrolled as an MCCP medical service provider.
- Accept MCCP reimbursement or a combination of other party payment and MCCP funds as payment in full for the allowed services. The total reimbursement to an enrolled medical service provider will not exceed the allowable Medicare reimbursement rate.
- Refrain from charging an MCCP client for any breast, cervical or colorectal screening services allowed through the MCCP.
- Complete all MCCP data collection forms and submit them to the administrative site.
- Submit claims to Montana Medical Billing.

The sequence of events for claims and reimbursement is as follows:

- Enrolled medical service providers send all claims to Montana Medical Billing. All claims should be made on CMS-1500 or on UB-92 forms. If further instruction is needed to complete forms please contact Montana Medical Billing, P O Box 5865, Helena, MT 59604 or 1-800-227-7065.
- Montana Medical Billing reviews all claims and designates reimbursement as either "pending", "approved" or "denied". Reimbursement is issued to medical service providers upon receipt of valid claims made on behalf of eligible MCCP clients. Enrolled medical service providers receive an explanation of benefits for each claim.

2. MCCP as Payer of Last Resort

The MCCP is the payer of last resort except for Indian Health Service. The enrolled medical service provider must determine whether a client is covered for the breast, cervical or colorectal cancer services provided completely or partially by any other sources. If the client is covered by other sources, providers must collect payment from these other sources before requesting reimbursement from MCCP.
Other sources of payment may include, but are not limited to:

- Private insurance
- Medicare (see eligibility guidelines for Medicare Part B recipients.)
- Medicaid Title X Family Planning
- Other private or public funded programs

Note: Through a Memorandum of Understanding with the Billings area Indian Health Service (IHS) and with tribal health units, the MCCP will reimburse enrolled medical service providers for procedures outlined on MCCP Reimbursement/Fee Schedule. Indian Health Service is the payor of last resort.

F. Service Restrictions

Please contact the regional cancer control specialist for all questions concerning medical service provider enrollment and medical service claims and reimbursement. In addition, please note the following service restrictions:

- MCCP funds may be used to reimburse enrolled medical service providers for allowed procedures only.
- Enrolled medical service providers may submit claims for usual and customary charges for each of the allowable CPT codes. The MCCP will only reimburse at the allowable Medicare rate.
- Any claim submitted for unallowable services will be denied.

Montana Cancer Screening Program
Provider Enrollment Application

Please type or print the requested information as completely as possible. If any field is not applicable, please enter N/A. If you need extra space to answer any question, please attach an additional page.

Provider Name: _____ ***or*** Clinic Name: _____

Board Certified (Y/N) ____ Certification Date ____/____/____ # _____ Medicare Participating: (Y/N) _____

Phone # (_____) _____ Fax # (_____) _____

Street Address: _____ City: _____State: _____ ZIP: _____

Mailing Address (if different): _____ Contact Person: _____

E-mail: _____ County: _____ Federal Tax ID #: _____

Payment Mailing Information *(Complete only if different than provider information above)*:

Name of office where check is to be sent: _____

Phone #: _____ Fax #: _____ E-mail: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Contact Person: _____

Provider Credentials
Montana providers must complete all required information below. Out-of-state providers must also attach copies of all required certifications.

_____Provider License Number - required for all practitioners and non-practitioner entities.
Physician Assistants list the name of supervising MD and include his/her license: _____

_____CLIA (Clinical Laboratory Improvement Act-) - required of all laboratories.

_____MQSA (FDA- Mammography Quality Standards Act) - required of all radiology facilities.

_____Insurance and/or Medicare Certification Number: _____
required for all practitioners and non-practitioner entities.

PRACTITIONERS

_____
Practitioner Name **Printed**

_____
Practitioner **Signature**

_____
NPI #

Date: _____/_____/_____

ORGANIZATIONS or NON-PRACTITIONER ENTITIES

_____
Authorized Representative Name **Printed**

_____
Title/Position of Authorized Representative **Printed**

_____
Authorized Representative **Signature**

_____
NPI #

Date: _____/_____/_____

PROVIDER AGREEMENT & SIGNATURE

THE PROVIDER CERTIFIES THAT THE INFORMATION PROVIDED ON THIS ENROLLMENT FORM IS, TO THE BEST OF THE PROVIDER'S KNOWLEDGE, TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ THIS ENTIRE FORM BEFORE SIGNING. IN CONSIDERATION OF PAYMENTS MADE FOR AUTHORIZED SERVICES TO ELIGIBLE CLIENTS, AND IN ACCORDANCE WITH ANY RESTRICTIONS NOTED HEREIN, THE PROVIDER AGREES TO THE FOLLOWING:

The Provider agrees to offer screening and diagnostic services within the Provider's general area of practice, in accordance with the Montana Cancer Screening Program (MCSP) Policy and Procedural Manual (the "MCSP manual"), to clients determined eligible by the Department of Public Health and Human Services (the "Department") through its MCSP.

The Provider agrees to comply with Title XV of the Public Health Service Act (42 U.S.C. 201 et seq.); the Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law 101-354) and its amendments; the Breast and Cervical Cancer Amendments of 1993 (Public Law 103-183); the Clients' Health Research and Prevention Amendments of 1998 (Public Law 105-340); the program policies and procedures in the MCSP manual; any relevant provisions of applicable state and federal laws and regulations; and the terms of this document. (Note: Copies of the above documents are available upon request from the MCSP.)

Before requesting reimbursement for services provided to an eligible client, the Provider agrees to confirm with reasonable certainty that the client is not covered, completely or partially, for services by other possible first paying sources: private insurance, Medicare, Medicaid, Title X Family Planning, Indian Health Service and other private or public funded programs. If a service is partially covered, the Provider agrees to bill the Department only the portion for which there is no coverage.

The Provider may bill the Department (a) for any service to an eligible client, including those not designated by a CPT code in the MCSP manual; and (b) at a level that is customary and usual for those services. The Department agrees to reimburse the provider only for services with CPT codes and rates outlined in the current MCSP fee schedule, which will be amended at least annually.

The Provider agrees to refrain from charging an eligible client or any member of the client's family for any services billable to that client under the MCSP. The Provider may bill an eligible client for services NOT covered by the MCSP provided that the client understands that the services being provided are not MCSP covered services and agrees in writing to pay for the services prior to their delivery.

The Provider agrees to maintain at its cost, throughout the term of this agreement, primary standard general liability insurance coverage inclusive of bodily injury, personal injury and property damage. The insurance must cover claims as may be caused by any act, omission, or negligence of the Provider, its officials, agents, employees, representatives, assigns or subcontractors. The general liability insurance coverage must be obtained with combined single limits of $1,000,000 per occurrence and $2,000,000 aggregate per year, from an insurer with a Best's Rating of no less than A-.

The Provider agrees to maintain at its cost, throughout the term of this agreement, professional liability insurance coverage against claims for harm to persons that may arise from the professional services provided through this agreement. The insurance must cover claims as may be caused by any act, omission, or negligence of the Provider, its officials, agents, employees, representatives, assigns or subcontractors. The Provider must provide occurrence coverage professional liability insurance with combined single units of $1,000,000 per occurrence and $2,000,000 aggregate per year, from an insurer with a Best's Rating of no less than A-.

The Provider agrees to, in accordance with relevant laws, regulations, and policies, to protect the confidentiality of any material and information concerning an applicant for, or recipient of MCSP services. The Provider agrees to obtain consent from eligible clients prior to releasing screening results to the Department or its representatives; the consent must meet the requirements of Section 50-16-526, Montana Code Annotated (MCA).

The Provider agrees to make and maintain records that fully document the extent, nature and type of services provided to MCSP clients that support the fee charged, or payment sought for the service, and demonstrates compliance with all applicable requirements. All records, documents and correspondence relative to this agreement must be retained for a period of five (5) years after either the date of the last record entry or, if an audit commences during that period, until the audit is completed and resolved, whichever date is later. Failure to retain adequate documentation for services billed may result in recovery of payments for services not adequately documented.

The Provider agrees to provide the United States Department of Health and Human Services, the Department, the Legislative Auditor, or their authorized agents, access to any records, documents, and correspondence necessary to determine compliance with this agreement.

The Provider agrees to comply with those federal requirements and assurances for recipients of federal monies listed in the Department's Certification of Compliance (6-99) (Attachment A) and OMB Standard Form 424B (7-97) (Attachment B), which are applicable to the Provider. The Provider is responsible for determining which requirements and assurances are applicable to the

Provider. The Provider shall provide for the compliance of any subcontractors with applicable federal requirements and assurances and any related reporting requirements.

As required by 31 U.S.C. 1352 and 45 CFR 93.100 et seq., the Provider may not use federally appropriated monies to influence or attempt to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress in connection with the awarding of any federal contract, the making of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement.

The Provider may not use any funds received under this agreement (a) other than for normal and recognized executive-legislative relationships, to fund publicity or propaganda, or the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the U.S. Congress, a state legislature, or a local legislative body, except in presentation to the U.S. Congress or a state or local legislative body itself; or (b) to pay the salary or expenses of any grant or contract recipient, or agent acting for the recipient, related to any activity designed to influence legislation or appropriations pending before the U.S. Congress, a state legislature, or a local legislative body.

The Provider assures the Department that the Provider is an independent contractor providing services for the MCSP and that neither the Provider nor any of the Provider's employees are employees of the MCSP under this agreement or any subsequent amendment. The Provider is solely responsible for and shall meet all legal requirements, including payment of all applicable taxes, workers compensation, unemployment and other premiums, deductions, withholdings, overtime and other amounts which may be legally required with respect to the Provider and the employment of all persons providing services under this agreement.

The Provider agrees to indemnify, defend, and hold harmless the State of Montana, its officials, agents, and employees from any breach of this contract by the Provider, from any matters arising from the provision of services by the Provider under the contract, or from the Provider's failure to comply with any federal, state, or local laws, rules, or ordinances applicable to the services to be provided under this contract. This indemnification applies to all claims, obligations, liabilities, costs, attorney's fees, losses, or suits resulting from any acts, errors, omissions or negligence, whether willful or not, of the Provider; the Provider's employees, agents, subcontractors, or assignees; and any other person or entity performing services or providing materials under this contract.

The Provider agrees to comply with the Montana Human Rights Act, the Civil Rights Act of 1964 (42 U.S.C. 2000d, et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990 (42 U.S.C. 12101, et seq.), and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794).

The Provider may not, on the grounds of race, color, national original, creed, sex, religion, political ideas, marital status, age or disability exclude persons from employment in, deny participation in, deny benefits to, or otherwise subject persons to discrimination under the MCSP or any activity connected with the provision of MCSP services. All hiring done in connection with this agreement must be done on the basis of merit qualifications genuinely related to competent performance of the particular occupational task. The Provider, in accordance with federal Executive Orders 11246 and 11375 and 41 CFR Part 60, must provide for equal employment opportunities in its employment practices.

Either party may terminate this agreement by giving notice in writing to the other party 30 days prior to termination, except that the Department may, by written notice to the Provider, immediately terminate this agreement if the Provider fails to (a) perform any requirement of this agreement or (b) comply with any law, regulation or licensure and certification requirement. The Provider agrees to notify patients in writing of their withdrawal from the program prior to rendering additional services.

Prior to the signing of this agreement, the Provider must complete and submit to the Department: (a) a certificate of coverage for Workers' Compensation insurance or, if appropriate, an independent contractor's exemption; (b) a certificate of insurance indicating compliance with the requisite insurance coverages; (c) the Department's Certification of Compliance (June 1999); and (d) OMB Standard Form 424B (7-97). The Provider must submit a revised form or certification immediately upon any change in circumstances that effect a substantive change in the information or assurances provided through any particular form or certification.

The Provider acknowledges that this enrollment is effective only for the MCSP services noted above. I UNDERSTAND THAT PAYMENT OF CLAIMS WILL BE FROM FEDERAL FUNDS AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL OR STATE LAW.

Please return completed forms to your Administrative Site or mail to:

Montana Medical Billing – MCSP Unit
PO Box 5865
Helena, MT 59604
(406) 227-7065 or 1-888-227-7065

MONTANA CANCER CONTROL PROGRAMS

Department of Public Health & Human Services
Cogswell Building, 1400 Broadway
P.O. Box 202951
Helena, MT 59620-2951

Dear Health Care Provider:

Thank you for your interest in participating in the Montana Cancer Screening Program (MCSP). Please complete the Provider Enrollment Application in the following manner:

1. **Complete and sign the enclosed application.**

   - If the application is for an individual, the individual who will be providing the service must sign it.

   - If the application is for a facility, an individual authorized to enter the facility into a legal contract must sign it.

   - Providers are required to have one enrollment application for each provider and/or facility. Example: If you have a group of providers in one clinic, each applicant must complete an MCSP application.

2. If you are an out-of-state provider, please attach all license, certification and insurance information to the application. If you are an in-state provider, please reference your required documentation (you do not need to attach copies) the MCSP will verify your information. You may be required to enclose a photocopy of your Medicare Certification Notice.

3. If you are enrolling to bill for a service you have already provided, all required paperwork must be completed prior to approval. Retroactive enrollment is limited to 30 days from the date services were provided to the date enrollment the application was received. Retroactive enrollment is not guaranteed.

You will be notified in writing of the disposition of your enrollment request. Please do not bill Montana Medical Billing for any MCSP services until you have received approval, effective date, and a provider number.

If you have any questions regarding information required for the fields on the enrollment application, please contact:

Montana Medical Billing
MBCHP Unit at (406) 227-7065 or toll free at (888) 227-7065.

Form **W-9**
(Rev. January 2003)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ---------- ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 3.

Note: *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

Social security number
| | | – | | – | | | |

or

Employer identification number
| | – | | | | | | |

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item **2** above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item **2** does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here **Signature of U.S. person ►** **Date ►**

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a **nonresident alien or a foreign entity** not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments (29% **after** December 31, 2003; 28% **after** December 31, 2005). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will **not** be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under **4** above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate **Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note: *You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).*

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note: *If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.*

Exempt payees. Backup withholding is **not required** on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2);

2. The United States or any of its agencies or instrumentalities;

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities;

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities; or

5. An international organization or any of its agencies or instrumentalities.

Other payees that **may be exempt** from backup withholding include:

6. A corporation;

7. A foreign central bank of issue;

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States;

9. A futures commission merchant registered with the Commodity Futures Trading Commission;

10. A real estate investment trust;

11. An entity registered at all times during the tax year under the Investment Company Act of 1940;

12. A common trust fund operated by a bank under section 584(a);

13. A financial institution;

14. A middleman known in the investment community as a nominee or custodian; or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, **1** through **15.**

If the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for **9**
Broker transactions	Exempt recipients **1** through **13.** Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients **1** through **5**
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients **1** through **7** [2]

[1] See **Form 1099-MISC**, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are **not exempt** from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner **LLC** that is disregarded as an entity separate from its owner (see **Limited liability company (LLC)** on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note: *See the chart on page 4 for further clarification of name and TIN combinations.*

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5,** Application for a Social Security Card, from your local Social Security Administration office or get this form on-line at **www.ssa.gov/online/ss5.html**. You may also get this form by calling 1-800-772-1213. Use **Form W-7,** Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or **Form SS-4,** Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS Web Site at **www.irs.gov**.

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: *Writing "Applied For" means that you have already applied for a TIN **or** that you intend to apply for one soon.*

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see **Exempt from backup withholding** on page 2.

Signature requirements. Complete the certification as indicated in **1** through **5** below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item **2** in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item **2** of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA or Archer MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] **You must show your individual name,** but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: *If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.*

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or Archer MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, or to Federal and state agencies to enforce Federal nontax criminal laws and to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 30% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

OMB Approval No. 0348-0040

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
APPLICANT ORGANIZATION	DATE SUBMITTED

CERTIFICATION OF COMPLIANCE WITH CERTAIN REQUIREMENTS
FOR DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

MONTANA CANCER SCREENING PROGRAM PROVIDERS

(June 1999)

The Provider, _____, in relation to the performance of services under the proposed enrollment application and agreement, certifies to the Montana Department of Public Health & Human Services the following:

A That the Provider has not acted in collusion with other providers for the purpose of gaining unfair advantages for it or other providers or for the purpose of providing the services at a noncompetitive price or otherwise in a noncompetitive manner.

B. That the Provider, if receiving federal monies, nor any of its employees or a significant subcontractor in the performance of the duties and responsibilities of the proposed contract, are currently suspended, debarred, or otherwise prohibited from entering into a federally funded contract or participating in the performance of a federally funded contract.

That the Provider, if receiving $100,000 or more in federal monies, will submit to the Department the federal form "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions." Copies of the form are available from the Department.

C. That the Provider, if receiving federal monies, will not expend federal monies in violation of federal legal authorities prohibiting expenditure of federal funds on lobbying federal and state and local legislative bodies or for any effort to persuade the public to support or oppose legislation.

That the Provider, if receiving $100,000 or more in federal monies, will submit to the Department a certification statement as required by 45 CFR 93.110 and in the format presented in Appendix A to 45 CFR Part 93 certifying that no federal monies have been used in contravention of the lobbying prohibitions. Copies of the form are available from the Department.

That if any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress in connection with this agreement, the Provider will submit to the Department a disclosure form as required by 45 CFR 93.110 and in the format presented in Appendix B to 45 CFR Part 93, to report those funds. Copies of the form are available from the Department.

D. That the Provider prohibits, as required by federal legal authorities, smoking at any site of federally funded activities that serves youth under the age of 18. This is not applicable to sites funded with

Medicaid monies only or to sites used for inpatient drug or alcohol treatment.

E. That the Provider, if receiving federal monies, maintains drug free environments at its work sites, providing required notices, undertaking affirmative reporting, et al., as required by federal legal authorities.

F. That the Provider, if receiving federal monies, is not delinquent in the repayment of any debt owed to a federal entity.

G. That the Provider, if expending federal monies for research purposes, will comply with federal legal authorities relating to use of human subjects, animal welfare, biosafety, misconduct in science and metric conversion.

H. That the Provider, if receiving $100,000 or more in federal monies, will comply with all applicable standards and policies relating to energy efficiency which are contained in the state energy plan issued in compliance with the federal Energy Policy and Conservation Act.

Not all of these assurances may be pertinent to the Provider's circumstances. This certification form, however, is standardized for general use and signing it is intended to encompass only provisions applicable to the circumstances of the Provider in relation to the federal monies that are being received.

These assurances are in addition to those stated in Standard Form 424B(Rev. 7-97) of the federal Office of Management of the Budget (OMB). Standard Form 424B is an assurances form that must be signed by the Provider if the Provider is to be in receipt of federal monies.

There may be program specific assurances, not appearing either in this form or in the OMB Standard Form 424B, that the Provider may have to provide by certification.

This form, along with OMB Standard Form 424B, are to be provided with original signature to the Department's contract liaison. The completed forms are maintained by the Department in the pertinent purchase and contract files.

Further explanation of several of the requirements certified through this form may be found in the Department's standard Request For Proposal format document, standard contracting policy statement, and standard contract provisions. In addition, detailed explanations of federal requirements may be obtained through the Internet at sites for the federal departments and programs and for OMB and the General Services Administration.

_____
(Date)

_____
(Name of responsible officer)

_____
(Title of responsible officer

MONTANA CANCER CONTROL PROGRAMS

Breast and Cervical Eligibility and Enrollment Form

MONTANA Department of Public Health & Human Services

Eligibility Information

What is your age?	Do you have Medicare Part B? ☐ Yes ☐ No	Do you have Medicaid? ☐ Yes ☐ No
Family's yearly income before taxes	Do you have health insurance that Might cover these services? ☐ Yes ☐ No	
Number of people in household	Insurance Company	

Enrollment Information

Last Name	First Name	Middle Initial	Other Last Names Used
Date of Birth MM / DD / YYYY	Social Security Number	State	County
Mailing Address	Street Address		City
Home/Cell Phone	Work/Message Phone		Zip

Ethnic Background

Are you Hispanic? (Spanish/ Hispanic / Latino)

☐ Yes ☐ No ☐ Unknown

Race: Check all races that apply.

- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Unknown

Medical Background

Are you having any breast problems? ☐ Yes ☐ No

Do you have breast implants? ☐ Yes ☐ No

Have you ever had a mammogram? ☐ Yes ☐ No

Date of last mammogram _____ MM / DD / YYYY

Have you ever had a Pap test? ☐ Yes ☐ No

Date of last Pap _____ MM / DD / YYYY

Have you ever had a hysterectomy? ☐ Yes ☐ No

☐ **Do you use tobacco? – If yes, refer the client to the MT Quit Line.**

How did you hear about the program? Please check all that apply.

☐ Radio	☐ Presentation	☐ Pink/Purple Card (Pamphlet)	☐ Special Promotion/Event/Ad
☐ TV	☐ Medical Provider	☐ Government Office	☐ Newspaper/Newsletter
☐ Internet	☐ MAIWHC	☐ Re-screen/Previously Enrolled	☐ Fair-Job/Health or Pow Wow
☐ Family/Friend/Word of Mouth		☐ _____	

PLEASE READ AND SIGN THE

INFORMED CONSENT AND AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION

Office Use Only Fiscal Yr _____ Admin Site # _____ State ID _____

Form(s) submitted ☐ **New Screening Cycle** ☐ **Re-submitted with revisions**

Eligibility determined by (please print)_____ Date MM / DD / YYYY

Client under age - prior approval given by _____ Date MM / DD / YYYY

☐ Client under age (18-29) - meets criteria

MONTANA CANCER CONTROL PROGRAMS

Please Read and Sign

MONTANA Department of Public Health & Human Services

Client Name:	**Social Security Number:**

Informed Consent and Authorization to Disclose Health Care Information

The Montana Cancer Screening Program (MCSP) receives funds from the Center for Disease Control and Prevention (CDC) to provide cancer screening for age and income eligible Montana residents. Montana men and women can be screened through this program for colorectal cancer and women can also receive breast and cervical cancer screenings. Each time a client is screened for colorectal cancer, they may receive either an FOBT/FIT test or a colonoscopy. If any of the initial tests for colorectal cancer are abnormal, further diagnostic testing may be required, which may include a diagnostic colonoscopy and/or biopsy of colon tissue. Each time a client is screened for breast cancer, they may receive a clinical breast exam and breast X-ray called a mammogram. for cervical cancer, a client may receive a pelvic examination and a Pap test. If any of the initial tests for breast and cervical cancer are abnormal, further diagnostic testing may be required, which may include a diagnostic mammogram, ultrasound, and/or biopsy of the breast or cervical tissue. MCSP will provide case management services that will help you complete all the diagnostic tests and find resources that may help for treatment (if necessary). By enrolling in the MCSP you are accepting responsibility for keeping appointments and completing all the screening and diagnostic tests that are recommended by your medical provider.

Services Not Covered

The MCSP only provides services for colorectal, breast and cervical cancer screening and limited diagnostic tests. The program does not cover services for other health conditions, some diagnostic services, or cancer treatment. If I need services that are not covered, the MCSP staff will refer me to agencies that may help provide treatment. I understand that I may be billed for services not covered by the MCSP.

Insurance Information

I understand I have met the eligibility guidelines for the MCSP. I may have insurance coverage and still be eligible to participate. However, my insurance will be billed first for cancer screening services. If the services are not fully reimbursed by my insurance, the MCSP will pay the unpaid balance up to the maximum allowable Medicare reimbursement rate.

Confidentiality

Any information provided by me will remain confidential, which means that the information will be available only to me, my health care provider, and to the MCSP staff. The MCSP staff means those personnel and the Montana Department of Public Health and Human Services, administrative site and the tribal organizations and Indian Health Service Units who are specifically designated to work in the MCSP. Program reports will include information on groups of clients and will not identify any client by name or tribal affiliation.

Authorization to Disclose Health Care Information

I consent to and authorize the mutual exchange of screening and diagnostic records among the MCSP staff, my health care provider(s), the laboratory reading my FIT and/or Pap smear, and the radiology facility where my mammogram is performed with respect to MCSP related services received by me up to six months after the date indicated below. This authorization expires thirty months after the date I signed below.

I have read the information provided herein, discussed this and other information about the MCSP and agree to participate in the program. I have had an opportunity to ask question about the MCSP and have received answers to any question I had. All information, including financial and insurance benefits, I have provided to the MCSP is, to the best of my knowledge, true. I understand that my participation is voluntary and that I may drop out the MCSP at any time.

Client Signature: _____	**Date:** _____ MM / DD / YYYY
Print Full Name: _____	

MONTANA CANCER CONTROL PROGRAMS

Breast and Cervical Screening Form

MONTANA Department of Public Health & Human Services

Client Name	Phone Number	State ID	
Social Security Number - -	Date of Birth MM / DD / YYYY	Admin Site #	☐ Revised

CERVICAL CANCER SCREEN RESULTS

Date of Pap test MM / DD / YYYY

Pap specimen type ☐ Liquid ☐ Conventional

Adequacy of Pap specimen ☐ Satisfactory ☐ Unsatisfactory

Result of screening Pap test
- ☐ Negative for intraepithelial lesion or malignancy
- ☐ ASC-US
- ☐ Low Grade SIL (including HPV changes)
- ☐ **ASC-H**
- ☐ **High Grade SIL**
- ☐ **Squamous Cell Carcinoma**
- ☐ **Abnormal Glandular Cells**

Date of HPV/DNA test MM / DD / YYYY

High Risk HPV/DNA test results if done

☐ **Positive** ☐ Negative

Paid by MCSP Pap test ☐ Yes ☐ No
HPV/DNA test ☐ Yes ☐ No

Reason for Pap test
- ☐ Routine screening
- ☐ Surveillance, follow-up of previous abnormal
- ☐ Done outside the MCSP, diagnostics only
- ☐ Not done, diagnostics only
- ☐ Breast record only

Date referred to the MCSP for diagnostic workup

Date referred MM / DD / YYYY

Additional procedures
- ☐ Not planned, normal follow-up
- ☐ Planned, further diagnostic tests needed

Next Pap test or follow-up due MM / DD / YYYY

Recommendations/comments_____

_____

Provider's signature _____

Print provider's name_____

Respond for ALL clients screened for cervical cancer

Has this client had a hysterectomy? ☐ Yes ☐ No

If "Yes" was the hysterectomy
Due to cervical neoplasia? ☐ Yes ☐ No

Is the cervix still present? ☐ Yes ☐ No

A client who has had a hysterectomy is eligible for an MCSP Pap test if the hysterectomy was due to cervical neoplasia or the cervix is present.

Respond for clients with a NORMAL Pap test result

Recommend the cervical cancer screening interval for this client.
- ☐ Short term follow-up, abnormal protocol
- ☐ Annual, conventional Pap test
- ☐ Every 2 years, liquid based cytology
- ☐ Every 3 years, 3 normal Pap tests within 60 months

BREAST CANCER SCREEN RESULTS

Date of Clinical Breast Exam MM / DD / YYYY

Clinical Breast Exam (CBE) findings
- ☐ Normal exam
- ☐ Benign findings
- ☐ **Abnormal, suspicious for cancer**
- ☐ CBE not done

Date of Mammogram MM / DD / YYYY

Mammogram type ☐ **Digital** ☐ **Conventional**

Mammography test results - BI-RAD Categories
- ☐ Negative: Category 1
- ☐ Benign: Category 2
- ☐ Probably benign short interval follow-up suggested: Category 3
- ☐ **Suspicious Abnormality: Category 4**
- ☐ **Highly suggestive of malignancy: Category 5**
- ☐ **Assessment Incomplete: Category 0**

Paid by the MCSP CBE ☐ Yes ☐ No
Mammogram ☐ Yes ☐ No

Reason for Mammography test
- ☐ Routine screening
- ☐ Evaluate symptoms, positive CBE/prev abnormal mammogram
- ☐ Done outside the MCSP, diagnostics only
- ☐ Not done only received CBE or diagnostics
- ☐ Cervical record only

Date referred to the MCSP for diagnostic workup

Date referred MM / DD / YYYY

Additional procedures
- ☐ Not planned, normal follow-up
- ☐ Planned, further diagnostic tests needed

Next breast screening or follow-up due MM / DD / YYYY

Recommendations/comments_____

_____

Provider's signature_____

Print provider's name _____

MONTANA CANCER CONTROL PROGRAMS

Breast and Cervical Abnormal Form

MONTANA
Department of Public Health & Human Services

Client Name	Phone Number	State ID	
Social Security Number - -	Date of Birth MM / DD / YYYY	Admin Site #	☐ Revised

Additional Procedures	Date	Results	☐ Diagnostics Paid by MCSP
Imaging Procedures		**Result of imaging procedure**	
Additional mammographic views	____/____/_____	☐ Done _____	
Ultrasound	____/____/_____	☐ Done _____	
Film comparison (to evaluate assessment incomplete)	____/____/_____	☐ Done _____	
Final imaging outcome (Includes all imaging procedures and film comparisons done.)	____/____/_____	☐ Negative (1) ☐ Benign (2) ☐ Probably Benign (3) ☐ Suspicious Abnormality (4) ☐ Highly suggestive of malignancy (5)	
Surgical consult, repeat breast exam	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	
Fine needle biopsy/cyst aspiration	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	
Incisional biopsy	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	
Excisional biopsy	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	
Colposcopy directed biopsy/ECC	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	
Diagnostic LEEP	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	
Diagnostic cold knife cone	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	
Diagnostic endocervical curettage	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	
Gyn consult	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	
Other - list: _____	____/____/_____	☐ Normal: probably benign ☐ Abnormal: suspicious for cancer	

Breast Final Diagnosis

☐ Cancer not diagnosed

☐ Cancer, in-situ - LCIS

☐ **Cancer, in-situ - DCIS**

☐ **Cancer, invasive**

Cervical Final Diagnosis

☐ Normal/benign/inflammation

☐ HPV/condylomata/Atypia

☐ Mild dysplasia/CIN I (bx dx)

☐ Low grade SIL (bx dx)

☐ **Moderate dysplasia/CIN II** (bx dx)

☐ **High grade SIL** (bx dx)

☐ **Severe dysplasia/CIN III/Carcinoma in situ** (bx dx)

☐ **Invasive cervical carcinoma** (bx dx)

☐ Other - List: _____

Complete for Breast and /or Cervical Findings

Status of final diagnosis/imaging: (**date is required)**

☐ Workup complete Date _____/_____/_____

☐ Workup refused Date _____/_____/_____

☐ Lost to follow-up Date _____/_____/_____

Comments _____

_____

Status of treatment: (**required for bolded final diagnoses)**

☐ Started Date _____/_____/_____

☐ Refused Date _____/_____/_____

☐ Lost to follow-up Date _____/_____/_____

Next screening or follow-up due _____/_____
Month Year

Provider's signature _____

Print provider's name _____

MONTANA CANCER CONTROL PROGRAMS

Colorectal Eligibility & Enrollment Form

MONTANA Department of Public Health & Human Services

Last Name	First Name	Middle Initial	Other Last Names Used (*If Applicable*)

Birth date MM / DD / YYYY	Gender ☐ Male ☐ Female	Social Security Number - -	State	County

Mailing Address	City	Zip

Family Income before Taxes	Number of People in Household	Home/Cell Phone	Work Phone

Do you have Medicare Part B? ☐ Yes ☐ No	Do you have Medicaid? ☐ Yes ☐ No	Do you have health insurance that <u>might</u> cover these services? ☐ Yes ☐ No	Insurance Company

Ethnic Background Are you Hispanic? *(Spanish/ Hispanic / Latino)*
☐ Yes ☐ No ☐ Unknown

Race: *Check all races that apply.*
☐ White ☐ American Indian or Alaska Native
☐ Asian ☐ Native Hawaiian /Other Pacific Islander
☐ Unknown ☐ Black/African American

How did you hear about the program? *Please check all that apply.*
☐ Doctor ☐ Other Health Care Provider ☐ Friend
☐ Newspaper ☐ NBCCEDP/Colorectal Program ☐ TV
☐ Mailing Flyer ☐ Magazine Article ☐ Radio
☐ Family Member ☐ Community Event
☐ Other _____

☐ **Do you use tobacco? – If yes, refer the client to the MT Quit Line.**

********** **Office Use Only** **********

Screening History/Risk Assessment

----------Test result----------

Enter data on the colorectal screening tests the client has had.

Test Date MM/YYYY	Client had test Yes	No	Unknown	Normal / Negative	Normal/ Negative/ results other than polpy(s)/ tumor(s) or cancer	Abnormal / Positive	Polyp(s) / tumor(s) /cancer	Incomplete	Unknown
CRC Fecal take-home FOBT/FIT	☐	☐	☐	☐	N/A	☐	N/A	N/A	☐
Stool DNA	☐	☐	☐	☐	N/A	☐	N/A	☐	☐
Sigmoidoscopy	☐	☐	☐	N/A	☐	N/A	☐	☐	☐
Colonoscopy	☐	☐	☐	N/A	☐	N/A	☐	☐	☐
(DCBE) Double Contrast Barium Enema	☐	☐	☐	N/A	☐	N/A	☐	☐	☐
(CTC) Virtual Colonoscopy	☐	☐	☐	☐	☐	☐	☐	☐	☐

☐ Yes ☐ No ☐ Unknown **Have you been diagnosed with colorectal cancer or precancerous polyps?**
☐ Yes ☐ No ☐ Unknown **Has a blood relative been diagnosed with colorectal cancer or precancerous polyps?**

Are you currently experiencing colorectal cancer symptoms?
☐ Rectal bleeding, dark stool, blood in the stool within the past 6 months.
☐ Prolonged change in bowel habits: diarrhea/constipation for more than 2 weeks.
☐ Persistent abdominal pain.
☐ Symptoms of bowel obstruction, abdominal distension, nausea, vomiting.
☐ Significant unintentional weight loss of 10% or more of starting body weight.

Have you been diagnosed with or are you being treated for
☐ A genetic diagnosis of familial Adenomatous Polyposis (FAP) or Hereditary Non Polyposis Colorectal Cancer (HNPCC)?
☐ A clinical diagnosis or suspicion of FAP or HNPCC?
☐ Inflammatory Bowel Disease (Crohn's Disease or Ulcerative Colitis)?

☐ **Client Signed Informed Consent.**

Admin Site # _____ **State ID** _____

Eligibility Determined by: _____ **Date Eligible:** _____

MONTANA CANCER CONTROL PROGRAMS

Please Read and Sign

MONTANA Department of Public Health & Human Services

Client Name:	**Social Security Number:**

Informed Consent and Authorization to Disclose Health Care Information

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Client Signature: _____	**Date:** _____ MM / DD / YYYY
Print Full Name: _____	

MONTANA CANCER CONTROL PROGRAMS

Colorectal Screening Form

MONTANA Department of Public Health & Human Services

Last Name	First Name	Middle Initial	Birth Date	Admin Site #
			MM / DD / YYYY	

Social Security Number	Phone Number	State ID
- -		

Date initial test scheduled or fecal kit distributed

Date MM / DD / YYYY

Screening adherence
- ☐ Test done
- ☐ Not done, FOBT/FIT kit not returned
- ☐ Not done, appointment not kept.

Take home FOBT/FIT

Date MM / DD / YYYY

Indication for test
- ☐ Screening

Result
- ☐ Negative
- ☐ Positive
- ☐ Unknown

Outcome
- ☐ Complete
- ☐ Incomplete/Inadequate

Provider specialty
- ☐ General Practitioner
- ☐ Internist
- ☐ Family Practitioner
- ☐ Gastroenterologist
- ☐ General Surgeon
- ☐ Radiologist
- ☐ Colorectal Surgeon
- ☐ Physician Assistant
- ☐ OB/Gyn
- ☐ Registered Nurse
- ☐ Licensed Practical Nurse
- ☐ Nurse Practitioner

Next test recommended in this cycle
- ☐ Colonoscopy
- ☐ None, cycle complete

Colonoscopy Date MM / DD / YYYY

Indication for test
- ☐ Screening
- ☐ Surveillance
- ☐ Diagnostic

Result
- ☐ Normal/negative/diverticulitis/hemorrhoids
- ☐ Other findings, not suggestive of cancer/polyps
- ☐ Polyps/suspicious for cancer/presumed cancer
- ☐ Inadequate/Incomplete test with no findings

Outcome
- ☐ Complete
- ☐ Incomplete/Inadequate

Was the cecum reached during this colonoscopy?
- ☐ Yes
- ☐ No
- ☐ Unknown

Provider specialty
- ☐ General Practitioner
- ☐ Internist
- ☐ Family Practitioner
- ☐ Gastroenterologist
- ☐ General Surgeon
- ☐ Radiologist
- ☐ Colorectal Surgeon
- ☐ Physician Assistant
- ☐ OB/Gyn
- ☐ Registered Nurse
- ☐ Licensed Practical Nurse
- ☐ Nurse Practitioner

Was a biopsy/polypectomy performed during the endoscopy?
- ☐ Yes
- ☐ No

Adequate bowel preparation (decided by the clinician that did endoscopy)
- ☐ Yes
- ☐ No

Next test recommended in this cycle
- ☐ Surgery to complete diagnosis
- ☐ Colonoscopy
- ☐ None, cycle complete

Status of final diagnosis
- ☐ Complete
- ☐ Pending
- ☐ Refused diagnostic follow-up
- ☐ Lost to follow-up before final diagnosis

Date of final diagnosis, refused, or lost to follow up

MM / DD / YYYY

Final Diagnosis
- ☐ Normal/Negative
- ☐ Hyperplastic polyps
- ☐ Adenomatous polyp, no high grade dysplasia
- ☐ Adenomatous polyp, with high grade dysplasia
- ☐ Cancer

Recurrent Cancers
- ☐ New colorectal cancer, primary
- ☐ Recurrent colorectal cancer
- ☐ Non colorectal cancer primary (metastasis from another organ)
- ☐ Unknown

Recommended test for next cycle:
- ☐ Take home FOB/FIT
- ☐ Colonoscopy
- ☐ None

If client has a polypectomy, biopsy or surgery, complete the Colorectal Abnormal Form.

Provider signature _____ **Provider name** _____

MONTANA CANCER CONTROL PROGRAMS

Colorectal Abnormal Form

MONTANA
Department of Public Health & Human Services

Last Name	First Name	Middle Initial	Birth Date	Admin Site #
			MM / DD / YYYY	

Social Security Number	Phone Number	State ID
- -		

Histology of most severe polyp/lesion
(*Complete if biopsy/polypectomy was done during the colonoscopy)*
- ☐ Normal or other non-polyp histology
- ☐ Non-adenomatous polyp (inflammatory, hamartomatous, etc.)
- ☐ Hyperplastic polyp
- ☐ Adenoma, NOS (no high grade dysplasia noted)
- ☐ Adenoma, tubular (no high grade dysplasia noted)
- ☐ Adenoma, mixed tubular villous (no high grade dysplasia noted)
- ☐ Adenoma, villous (no high grade dysplasia noted))
- ☐ Adenoma, serrated (no high grade dysplasia noted)
- ☐ Adenoma with high grade dysplasia (includes in situ carcinoma)
- ☐ Adenocarcinoma, invasive
- ☐ Cancer, other
- ☐ Unknown/other lesions ablated, not retrieved or confirmed

Number of adenomatous polyps/lesions
(Complete if result of the histology is Adenoma or Cancer)
- ☐ Less than 97--Enter the number _____
- ☐ 97 or more adenomatous polyps/lesions
- ☐ At least one adenomatous polyps/lesions, exact number not known
- ☐ Unknown

Size of largest adenomatous polyp/lesion
(Complete if result of the histology is Adenoma or Cancer)
- ☐ Less than 1 cm
- ☐ Greater than or equal to 1 cm
- ☐ Unknown

Complications of endoscopy requiring observation or treatment.
(*Report the worst of up to 2 serious complication of CRC testing occurring within 30 days of the test date and resulting in an ER visit or hospitalization.)*
- ☐ No complications
- ☐ Bleeding, transfusion required
- ☐ Bleeding not requiring transfusion
- ☐ Cardiopulmonary events (hypotension, hypoxia, arrhythmia, etc)
- ☐ Complications related to anesthesia
- ☐ Bowel perforation
- ☐ Post-polypectomy syndrome/excessive abdominal pain
- ☐ Death
- ☐ Other _____

Provider's Signature _____

Histology from surgical resection
(*Complete if surgery was performed to complete diagnosis.)*
- ☐ Surgery recommended but not performed
- ☐ Normal or other non-polyp histology
- ☐ Non-adenomatous polyp (inflammatory, hamartomatous, etc.)
- ☐ Hyperplastic polyp
- ☐ Adenoma, NOS (no high grade dysplasia noted)
- ☐ Adenoma, tubular (no high grade dysplasia noted)
- ☐ Adenoma, mixed tubular villous (no high grade dysplasia noted)
- ☐ Adenoma, villous (no high grade dysplasia noted))
- ☐ Adenoma, serrated (no high grade dysplasia noted)
- ☐ Adenoma with high grade dysplasia (includes in situ carcinoma)
- ☐ Adenocarcinoma, invasive
- ☐ Cancer, other
- ☐ Unknown/other lesions ablated, not retrieved or confirmed

Date surgery performed MM / DD / YYYY

Complete this section if final diagnosis is Cancer

Status of treatment
- ☐ Started and/or complete
- ☐ Not recommended due to polypectomy
- ☐ Not recommended
- ☐ Refused
- ☐ Lost to follow-up

Date of treatment MM / DD / YYYY

Recommended test screening or surveillance test for next cycle
- ☐ Take home FOBT
- ☐ Take home FIT
- ☐ Colonoscopy
- ☐ None

Number of months before screening or surveillance test for next cycle. _____ (If none, leave blank)

Indication for screening or surveillance test for next cycle
- ☐ Screening
- ☐ Surveillance after a positive colonoscopy and/or surgery

Print Provider's Name _____

4 BREAST CANCER SCREENING

A. General Description

1. Covered Services

All eligible women enrolled in the Montana Cancer Control Programs (MCCP) shall receive the following comprehensive screening services for breast cancer, annually or as indicated:

- Clinical breast exam
- Referral for a screening or diagnostic mammogram
- Diagnostic services including biopsy
- Referral to the Montana Breast and Cervical Cancer Treatment Program (MBCCTP) if necessary

See www.cancer.mt.gov for a complete list of screening and diagnostic procedures and reimbursement rates.

Please note that MCCP funds may not be used for treatment services.

2. Enrollment and Screening Steps

a. Complete MCCP enrollment forms, paying particular attention to the following:
   - Ensure that each client signs an "Informed Consent and Authorization to Disclose Health Care Information." This form must be signed before any services can be provided.

b. Determine which screening services a client needs.
c. Perform appropriate screening and refer the client for diagnostic tests in accordance with the MCCP algorithms.
d. Notify all clients of all test results.
e. If results are abnormal, conduct appropriate tracking and follow-up.
f. Send rescreening reminders to all clients.

B. Eligibility

1. General Criteria

The MCCP will provide screening services to women who meet all of the following criteria:

- Are 50 through 64 years of age for breast cancer screening, with limited funding for 40-49 years of age.
- Are uninsured or underinsured.
- Have a family gross income at or below 200 percent of the current Federal Poverty Level (FPL) scale (see the MCCP Website, www.cancer.mt.gov, under Income Guidelines.)[1]

Clients must provide the information needed to determine eligibility on the MCCP "Eligibility and Enrollment" form. If a woman is ineligible for MCCP services, she should be referred to other community agencies that may be able to assist her.

Only women diagnosed through the MCCP for breast cancer or a pre-cancerous condition may apply for the MBCCTP.

If a client misrepresents her eligibility, the MCCP will deny reimbursement for screening services and refer the client to the health or social service agency that may be able to assist her.

2. Exception to the Age Criteria for Eligibility

Presuming a woman is otherwise MCCP eligible; the following criteria for age will be used to determine eligibility for breast cancer screening and diagnostic funds:

- Women ages 50 through 64 and ages 65 and older that do not have Medicare part B, are MCCP eligible for breast cancer screening services.
- Women ages 40 through 49 will be determined MCCP eligible for breast cancer screening services based on an allocated percentage of available funds.
- Women ages 39 and younger MUST be pre-approved for eligibility and MUST be referred by a surgeon or consulting breast specialist. The criteria that will be considered to determine MCCP eligibility for this age category will include but may or may not be limited to one of the following:
    - A mammogram result of BI-RAD category "4" or "5".
    - A clinical breast exam (CBE) after consultation with a surgeon or consulting breast specialist that is suspicious for breast cancer, in concert with other clinical findings that are suspicious for breast cancer, for example abnormal ultrasound, abnormal mammogram, abnormal cytology/pathology from a needle core exam.
    - A family history of pre-menopausal breast cancer in concert with other clinical findings determined to be suspicious for breast cancer, for example breast mass, abnormal ultrasound, abnormal mammogram.
    - A documented history of a previous biopsy diagnosis of breast cancer.

[1]The Federal Poverty Level scale is updated each year.

3. Women who have the following abnormal test results are eligible for patient navigation.

- Clinical Breast Exam
  - Abnormal, Suspicious for Cancer
- Mammography Test Results
  - BI-RAD Category 4 – Suspicious Abnormality
  - BI-RAD Category 5 – Highly Suggestive of Malignancy
  - BI-RAD Category 0 – Assessment Incomplete

C. Reporting Systems

1. Breast Screening and Diagnostic Tests

Use the following when reporting on services provided to MCCP clients:

a. Breast screenings
   - "Breast Screening Results" form
   - "Abnormal Breast Screening Results" form

b. Mammography test results
   - Breast Imaging Reporting and Data System—BI-RADS, 2nd edition

c. Breast cancer staging
   - American Joint Committee on Cancer Staging: Staging for Breast Carcinoma, 3rd edition

D. Summary of Performance Indicators

Proposed Indicator Type, Number and Description			CDC Benchmark
Screening Priority Population	1	Percent of mammograms provided to women ≥ 50 years of age	≥ 75%
Completeness of Clinical Follow-up	2	Abnormal screening results with complete follow-up	≥ 90%
	4	Percent of diagnosed cancers with treatment initiated	≥ 90%
Timeliness of Clinical Follow-up	5	Percent of abnormal screening results; time from screening to diagnosis within 60 days	≥ 80%
	6	Percent of cancers diagnosed with treatment initiated within 60 days	≥ 80%

E. Montana Breast and Cervical Cancer Treatment Program

The Montana Breast and Cervical Cancer Treatment Program (MBCCTP) provides basic Medicaid benefits to women in need of treatment for breast cancer, including pre-cancerous conditions.

In order to be eligible for MBCCTP services:

- The woman must be screened and/or diagnosed through the MCCP.
- The woman must have a diagnosis of breast cancer or a pre-cancerous condition dated July 1, 2001 or later.
- The woman may not have creditable insurance or other coverage to pay for treatment.
  - Medicaid will determine if the insurance coverage is creditable.
  - Medicaid will determine MBCCTP eligibility for women who may be eligible for Indian Health or Tribal Health services.
  - Medicaid will determine if the woman is eligible for any other Medicaid program which will cover these services.
- The woman must be less than 65 years of age. If she is over 65 years of age she will be referred to Medicare.
- Beneficiaries will receive Basic Medical Coverage and will remain eligible until one of the following occurs:
  - The treatment recommended by the medical services provider is complete.
  - All approved cases will be reviewed according to the estimated length of treatment indicated by their medical service provider.
  - The woman turns 65 years of age.
  - The woman obtains creditable insurance coverage.
  - The woman is eligible for other Medicaid coverage.
  - The woman becomes a resident of another state.

1. Process for Application and Eligibility Requirements

a. The State Public Assistance Bureau and the Montana Cancer Screening Program will facilitate applications and establish eligibility of potential clients.

b. The State Public Assistance Bureau will accept and approve all applications. Required documents include:
   - MBCCTP Medicaid Enrollment form, #HCS-BCC-002 (completed and signed by the client).
   - MBCCTP Medicaid Referral Form, #HCS-BCC-003 (completed and signed by the provider).
   - Montana Cancer Control Programs Enrollment form.
   - Proof of:
     - Age;
     - U.S. Citizenship, U.S. National or Alien Status; and
     - Montana residence (see list on application form)
   - Insurance card or policy name and number if applicable.

c. The State Public Assistance Bureau will notify clients of their eligibility status.
   - Medicaid cards will be issued to MBCCTP eligible clients monthly.
   - Women who are eligible for other Medicaid programs will be referred for application and must follow through to be eligible for MBCCTP coverage.

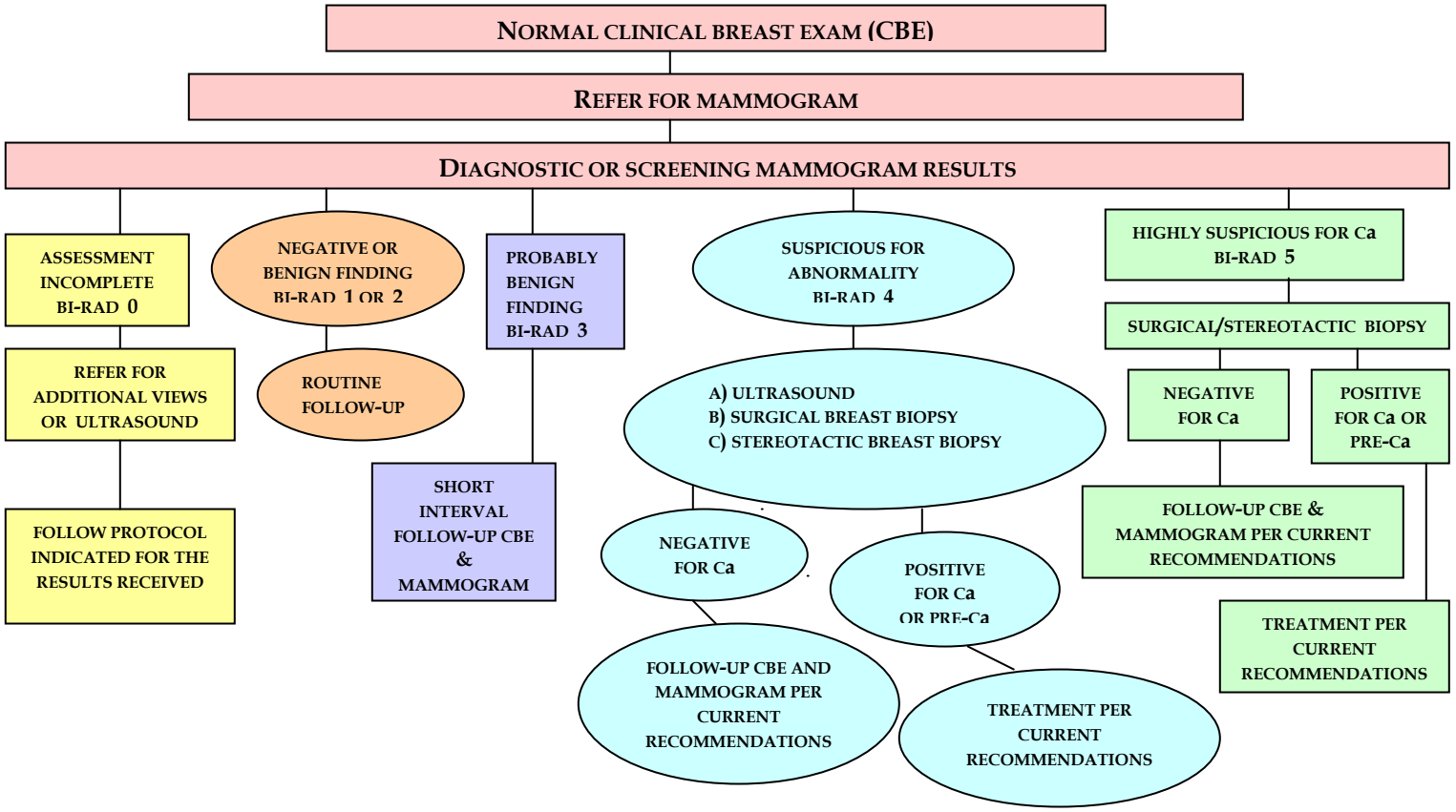
d. MBCCTP eligible clients will be required to participate in PASSPORT to Health.
   - MBCCTP clients will receive a welcome packet and a letter that instructs them to choose a PASSPORT Primary Care Provider (PCP).
   - If the woman does not complete the PASSPORT forms and chose a PCP, one will be assigned and the woman will be notified.
   - The PCP must provide "most" services for the client or give a referral to another provider or Medicaid *will not* pay the claim. (Referral # must be on the claim).

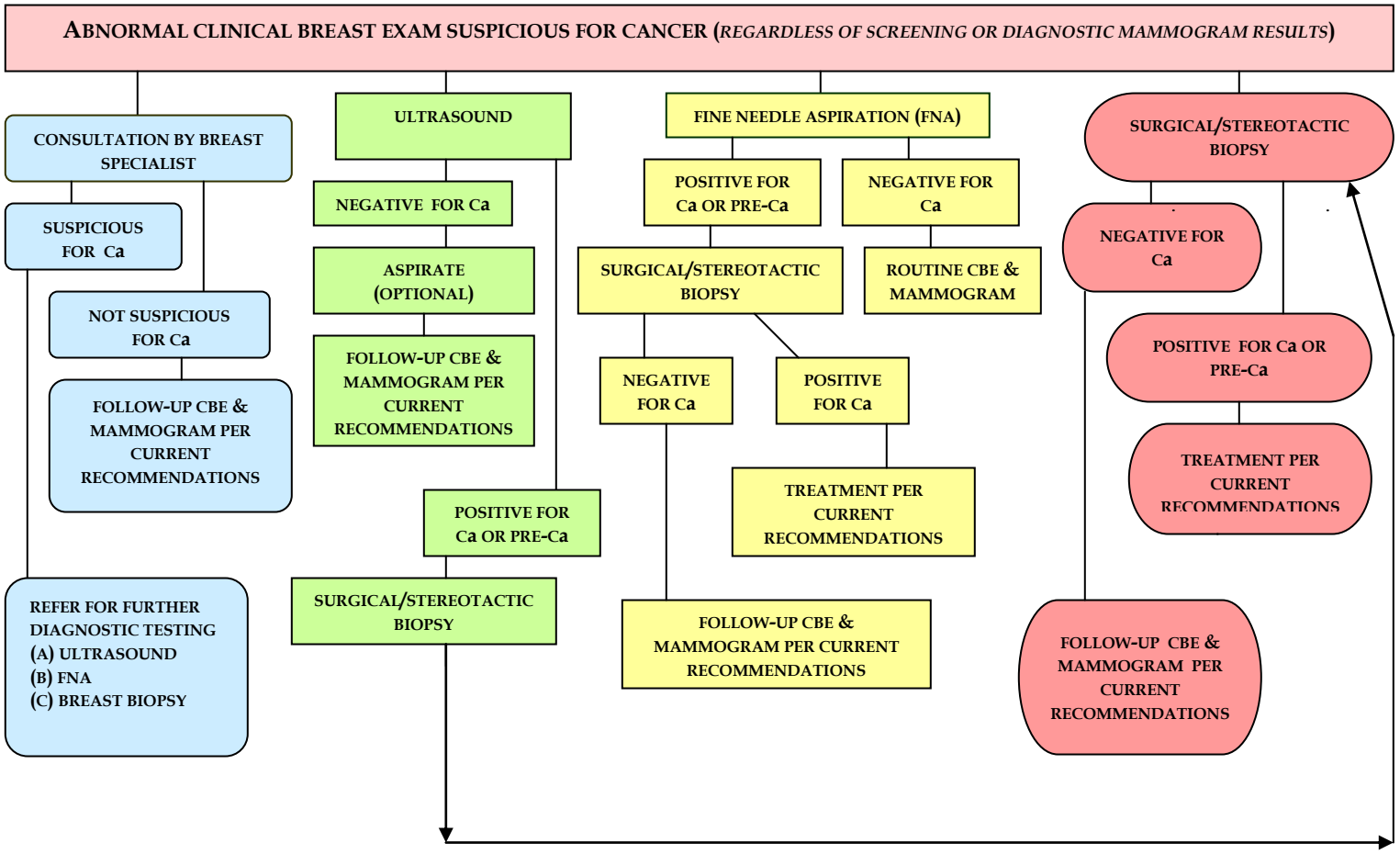
e. All applicants will be reviewed for continued eligibility three (3) months after the initial date of eligibility and annually thereafter.
   - Continued eligibility will be determined based on the recommendation of the client's PASSPORT Provider.

f. Eligibility will be discontinued when/if the:
   - Woman's PASSPORT Provider indicates treatment is complete
   - Woman becomes eligible for other Medicaid coverage
   - Woman turns 65 years old
   - Woman fails to cooperate or complete an eligibility redetermination

g. All women will be notified when their MBCCTP eligibility is discontinued and for what reason eligibility is ending.

Montana Breast and Cervical Health Program
Algorithm for Breast Cancer Screening





5 CERVICAL CANCER SCREENING

A. General Description

1. Covered Services

All eligible women enrolled in the Montana Cancer Control Programs (MCCP) shall receive the following comprehensive screening services for cervical cancer, annually or as indicated:

- bimanual pelvic examination
- Pap test, if indicated
- diagnostic services including biopsy
- referral to the Montana Breast and Cervical Cancer Treatment Program (MBCCTP) if necessary

See www.cancer.mt.gov for a complete list of screening and diagnostic procedures and reimbursement rates.

Please note that MCCP funds may not be used for treatment services.

2. Enrollment and Screening Steps

a. Determine whether a woman is eligible for services, either by telephone or an in-person interview.

b. Complete MCCP cervical enrollment forms, paying particular attention to the following:
   - Ensure that each client answers the enrollment question about whether she has ever had a Pap test and the date of the last Pap test.[1]
   - Ensure that each client signs an "Informed Consent and Authorization to Disclose Health Care Information." This form must be signed before any services can be provided.

c. Determine which screening services a client needs.

d. Perform appropriate screening and refer the client for diagnostic tests in accordance with the algorithms approved by the MCCP. Diagnostic tests will be eligible for MCCP reimbursement only if recommended and referred by an enrolled medical service provider.

e. Notify all clients of all test results.

[1] Data on prior Pap tests is needed in order to meet the MCCP goal to increase cervical screening for MCCP-eligible women who have never been screened or have not been screened within the past 5 years.

3. Reimbursement

MCCP will provide reimbursement for liquid-based cytology for primary cervical cancer screening, up to the allowable Medicare rate (effective July, 2007). The screening interval when using liquid-based tests is every two years.

B. Eligibility

1. General Criteria

As set forth in Public Law 101-354, the MCCP will provide screening services to women who meet all of the following criteria:

- Are 50 through 64 years of age for breast cancer screening and 30 through 64 for cervical cancer screening.
- Are uninsured or underinsured.
- Have a family gross income at or below 200 percent of the current Federal Poverty Level (FPL) scale (see the MBCHP Website, www.cancer.mt.gov, under Income Guidelines)[2].

If a client misrepresents her eligibility, the MCCP will deny reimbursement for screening services and refer the client to the health or social service agency that may be able to assist her.

2. Exception to the Age Criteria for Eligibility

Presuming a woman is otherwise MCCP eligible; the following criteria for age will be used to determine eligibility for cervical cancer screening and diagnostic funds:

- Women ages 30-64 and ages 65 and older that do not have Medicare part B, are MCCP eligible for cervical cancer screening services based on an allocated percentage of available funds.
- Women ages 18-29 are pre-approved for eligibility for cervical cancer screening if they have a:
  - Pap test result of High Grade SIL or more severe.
  - Diagnostic colposcopy result of CIN II, CIN III or invasive cervical cancer.
  - Documented history of a previous biopsy diagnosis of cervical cancer or a pre-cancerous condition that was not treated and/or treatment with no documented Pap test for these conditions.

[2]The Federal Poverty Level scale is updated each year.

3. Additional Eligibility Guidelines for Women Who have had a Hysterectomy

The MCCP anticipates that some women who meet the eligibility criteria described above will have had a hysterectomy. In these cases, the MCCP will reimburse enrolled medical service providers for initially determining whether a client requires continued cervical screening services. If a woman is recommended for continued cervical screening, the MCCP will employ the following guidelines:

- The MCCP will pay for Pap test screening for clients who have had a hysterectomy and still have a cervix. (A small percentage of women with hysterectomies have had a supracervical hysterectomy, which leaves the cervix intact).
- The MCCP will not pay for Pap test screening on clients whose hysterectomy included removal of the cervix, unless the client had a hysterectomy due to cervical neoplasia. (A small percentage of women have had hysterectomies for cervical neoplasia and have no cervix).

4. Additional Requirements for Cervical Screening

In addition to the above requirements for normal and abnormal results, requirements for cervical screening include:

- Provide Pap tests on an annual basis until a client has received three consecutive normal results within a 5-year (60-month) period. The MCCP will provide reimbursement for Pap tests provided according to these guidelines.
- After a client has had three consecutive normal Pap test results within a 5-year (60-month) period, provide subsequent Pap tests every 3 years. The MCCP will provide reimbursement for these subsequent Pap tests.

If a client receives an abnormal screening result at any time, follow the MCCP policies related to the follow-up of abnormal Pap tests and reimbursement of diagnostic procedures. Once the client has received the recommended follow-up services, the MCCP will provide reimbursement for additional annual Pap tests until three consecutive Pap tests within a 5-year (60-month) period yield normal results.

5. Women who have the following abnormal test results are eligible for patient navigation.

Cervical Screening Results:

- ASC-H (Atypical Squamous Cells: Cannot Exclude High-grade SIL)
- AGC (Atypical Glandular Cells)
- HSIL (High grade Squamous Intraepithelial Lesions)
- Squamous Cell Cancer

C. Reporting Systems

Cervical Screening and Diagnostic Tests

Use the following when reporting on services provided to MCCP clients:

- Cervical screenings
  - "Cervical Screening Results" form
  - "Abnormal Cervical Screening Results" form
- Pap test results
  - Bethesda System
- Cervical cancer staging
  - Staging of Carcinoma of the Uterine Cervix

D. Summary of Performance Indicators:

Proposed Indicator Type, Number and Description			**CDC Benchmark**
Screening Priority Population	1	Initial Program Pap tests; never or rarely screened (no Pap done within past 60 months.)	≥ 20%
Completeness of Clinical Follow-up	2	Abnormal screening results with complete follow-up	≥ 90%
	4	Percent of diagnosed cancers with treatment initiated	≥ 90%
Timeliness of Clinical Follow-up	5	Percent of abnormal screening results; time from screening to diagnosis within 90 days	≥ 75%
	6	Percent of HSIL, CIN2, CIN3, CIS diagnosed with treatment initiated within 90 days.	≥80 %
	7	Percent of invasive cancers diagnosed with treatment initiated within 60 days	≥ 80%

E. Montana Breast and Cervical Cancer Treatment Program

The Montana Breast and Cervical Cancer Treatment Program (MBCCTP) provides basic Medicaid benefits to women in need of treatment for breast cancer, including pre-cancerous conditions.

In order to be eligible for MBCCTP services:

- The woman must be screened and/or diagnosed through the MCCP.
- The woman must have a diagnosis of breast cancer or a pre-cancerous condition dated July 1, 2001 or later.
- The woman may not have creditable insurance or other coverage to pay for treatment.
  - Medicaid will determine if the insurance coverage is creditable.
  - Medicaid will determine MBCCTP eligibility for women who may be eligible for Indian Health or Tribal Health services.
  - Medicaid will determine if the woman is eligible for any other Medicaid program which will cover these services.
- The woman must be less than 65 years of age. If she is over 65 years of age she will be referred to Medicare.

Beneficiaries will receive Basic Medical Coverage and will remain eligible until one of the following occurs:

- The treatment recommended by the medical services provider is complete.
  - All approved cases will be reviewed according to the estimated length of treatment indicated by their medical service provider.
- The woman turns 65 years of age.
- The woman obtains creditable insurance coverage.
- The woman is eligible for other Medicaid coverage.
- The woman becomes a resident of another state.

1. Process for Application and Eligibility Requirements

a. The State Public Assistance Bureau and the Montana Cancer Screening Program will facilitate applications and establish eligibility of potential clients.

b. The State Public Assistance Bureau will accept and approve all applications. Required documents include:
   - MBCCTP Medicaid Enrollment form, #HCS-BCC-002 (completed and signed by the client).
   - MBCCTP Medicaid Referral Form, #HCS-BCC-003 (completed and signed by the provider).
   - Montana Cancer Control Programs Enrollment form.
   - Proof of:
     - Age
     - U.S. Citizenship, U.S. National or Alien Status
     - Montana residence (see list on application form)
   - Insurance card or policy name and number if applicable.

c. The State Public Assistance Bureau will notify clients of their eligibility status.
   - Medicaid cards will be issued to MBCCTP eligible clients monthly.
   - Women who are eligible for other Medicaid programs will be referred for application and must follow through to be eligible for MBCCTP coverage.

d. MBCCTP eligible clients will be required to participate in PASSPORT to Health.
   - MBCCTP clients will receive a welcome packet and a letter that instructs them to choose a PASSPORT Primary Care Provider (PCP).
   - If the woman does not complete the PASSPORT forms and chose a PCP, one will be assigned and the woman will be notified.
   - The PCP must provide "most" services for the client or give a referral to another provider or Medicaid *will not* pay the claim. (Referral # must be on the claim).

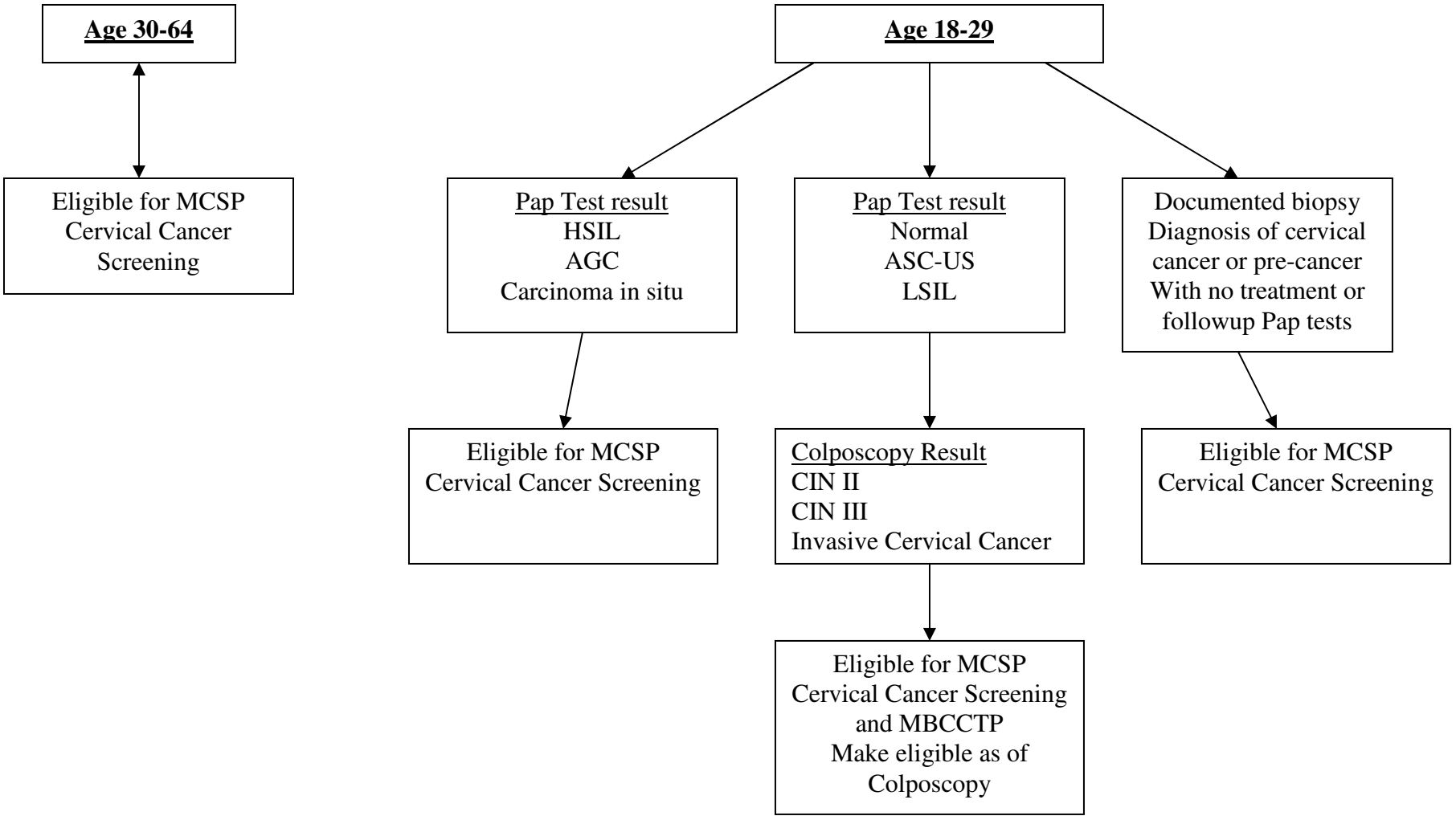
e. All applicants will be reviewed for continued eligibility three (3) months after the initial date of eligibility and annually thereafter.
   - Continued eligibility will be determined based on the recommendation of the client's PASSPORT Provider.

f. Eligibility will be discontinued when/if the:
   - Woman's PASSPORT Provider indicates treatment is complete.
   - Woman becomes eligible for other Medicaid coverage.
   - Woman turns 65 years old.
   - Woman fails to cooperate or complete an eligibility redetermination.

g. All women will be notified when their MBCCTP eligibility is discontinued and for what reason eligibility is ending.

Exception to the Age Criteria Eligibility for Cervical Cancer Screening

Presuming a client is otherwise eligible, and if she meets the conditions listed below you do NOT have to call the MCSP for pre-approval. Write "meets criteria" on the pre-approval line on the eligibility form.



MONTANA BREAST AND CERVICAL HEALTH PROGRAM
ALGORITHM FOR CERVICAL CANCER SCREENING

PAP TEST

- NEGATIVE
  - ROUTINE FOLLOW-UP
- ASC-US
  - REPEAT PAP @ 4-6 MONTHS
    - NEGATIVE
      - REPEAT PAP @ 4-6 MONTHS
        - NEGATIVE
          - ROUTINE FOLLOW-UP
        - ASC-US
          - COLPOSCOPY WITH BIOPSY & ECC
  - HPV DNA TESTING
    - NEGATIVE FOR HIGH RISK HPV
      - ROUTINE FOLLOW-UP
    - POSITIVE FOR HIGH RISK HPV
      - COLPOSCOPY WITH BIOPSY & ECC
- ASC-H
  - COLPOSCOPY WITH BIOPSY & ECC
- LSIL
  - COLPOSCOPY WITH BIOPSY & ECC
- HSIL AGC
  - COLPOSCOPY WITH BIOPSY & ECC
- SQUAMOUS CELL CANCER
  - COLPOSCOPY WITH BIOPSY & ECC

KEY:
ASC-US: Atypical Squamous Cells of Undetermined Significance
ASC-H: Atypical Squamous Cells: cannot exclude High-Grade SIL
AGC: Atypical Glandular Cells
LSIL: Low-Grade Squamous Intraepithelial Lesions
HSIL: High-Grade Squamous Intraepithelial Lesions

6 COLORECTAL CANCER SCREENING

A. General Description

1. Covered Services

a. Screening Tests

All eligible men and women enrolled in the Montana Cancer Control Programs (MCCP) shall receive the following screening services for colorectal cancer, annually or as indicated:

- High Sensitivity Fecal Occult Blood Test (FOBT)
- High Sensitivity Fecal Immunochemical Test (FIT)
- Colonoscopy
- Bowel Preparation
- Office Visits related to the above tests
- Biopsy/polypectomy during colonoscopy
- Standard anesthesia for colonoscopy
- Pathology fees

b. Surveillance Colonoscopies

Surveillance is defined as periodic colonoscopy on a person who has prior history of adenoma(s) or colorectal cancer for the purpose of removing polyps that were missed on the initial colonoscopy or that developed in the interval since the initial colonoscopy.

The timing of a surveillance colonoscopy after polypectomy depends on the size, type, histology, number and completeness of polyp removal during the initial colonoscopy. Surveillance after surgical resection of colorectal cancer depends on whether the cancer resulted in obstruction of the bowel and the presence of synchronous cancers or polyps on subsequent evaluations.

Recommendations for surveillance should follow guidelines in CRC Screening Algorithm.

See www.cancer.mt.gov for a complete list of screening and diagnostic procedures and reimbursement rates.

Please note that MCCP funds may not be used for treatment services.

2. Enrollment and Screening Steps

a. Determine whether a person is eligible for services, either by telephone or an in-person interview.

b. Complete MCCP enrollment forms, paying particular attention to the following:
   - Ensure that each client signs an "Informed Consent and Authorization to Disclose Health Care Information". This form must be signed before any services can be provided.
   - Ensure that screening history and risk assessment are completed.

c. Determine which screening services a client needs.

d. Perform appropriate screening and refer the client for diagnostic tests in accordance with the algorithms approved by the MCCP. Diagnostic tests will be eligible for MCCP reimbursement only if recommended and referred by an enrolled medical service provider.

e. Notify client of all test results.

f. If results are abnormal, conduct appropriate tracking and follow-up.

g. Send rescreening reminders to all clients.

3. Reimbursement

The MCCP will reimburse enrolled medical service providers for the cost of performing the covered services, provided these have been conducted in accordance with the algorithms approved by the MCCP (see www.cancer.mt.gov). Clients are responsible for paying for any other services or tests.

MCCP will only reimburse for FOBT and FIT tests that have high sensitivity. (See Algorithm Appendix)

The following services are not reimbursable:

- Flexible sigmoidoscopy unless there is a failure to reach the cecum during the scheduled screening colonoscopy (see D-6).
- CT Colonography (or virtual colonoscopy) as a primary screening test.
- Computed Tomography Scans (CTs or CAT scans) requested for staging or other purposes.
- Surgery or surgical staging, unless specifically required and approved by the program's MAB to provide a histological diagnosis of cancer.
- Any treatment related to the diagnosis of colorectal cancer.
- Any care or services for complications that result from screening or diagnostic tests provided by the program.
- Evaluation of symptoms for clients who present for CRC screening but are found to have gastrointestinal symptoms.
- Diagnostic services for clients who had an initial positive screening test performed outside of the program.
- Management of medical conditions, including Inflammatory Bowel Disease (e.g., surveillance colonoscopies and medical therapy).

- Genetic testing for clients who present with a history suggestive of a Hereditary Non-Polyposis Colorectal Cancer (HPNCC) or Familial Adenomatous Polyposis (FAP).

4. Anesthesia

Use of Propofol or a similar anesthesia used during endoscopy is not reimbursable by MCCP, unless specifically required and approved by the program in cases where the client cannot be sedated with standard moderate sedation.

- There are occasional circumstances where the use of Propofol or a similar anesthesia may be required in order to complete an endoscopy, these will be reviewed by MCCP on a case by case basis.
- Providers must document why using Propofol or a similar anesthesia was necessary.
- If it is determined during the colonoscopy that a client requires the use of Propofol or a similar anesthesia instead of standard moderate anesthesia, these claims will have a post procedure review by the MCCP.
- Reimbursement will be based on prior approval or post procedure review at the Medicare reimbursement rate for standard anesthesia.

B. Eligibility

1. General Criteria

The MCCP will provide screening services to men and women who meet all of the following criteria:

- 50 through 64 years of age.
- Uninsured or underinsured.
- Have a family gross income at or below 200 percent of the current Federal Poverty Level (FPL) scale (see the MBCHP Website, www.cancer.mt.gov, under Income Guidelines)[1].

Clients must provide the information needed to determine eligibility on the MCCP "Eligibility and Enrollment" form. If a person is ineligible for MCCP services, they should be referred to other community agencies that may be able to assist them.

If a client misrepresents their eligibility, the MCCP will deny reimbursement for screening services and refer the client to the health or social service agency that may be able to assist them.

2. Exception to the Age Criteria for Eligibility

Presuming a person is otherwise MCCP eligible; the following criteria for age will be used to determine eligibility for colorectal cancer screening and diagnostic funds:

- Persons 40-49 will be eligible for colorectal screening if they have a family history of polyps or CRC.

[1]The Federal Poverty Level scale is updated each year.

3. Additional Eligibility Guidelines for Colorectal Screening

a. Average Risk

Screening efforts should focus on people between the age of 50 and 64 years who are at average risk for CRC. Average risk is generally defined as:

- No personal or family history of CRC or adenomas
- No history of inflammatory bowel disease (Ulcerative Colitis or Crohn's Disease)
- No history of genetic syndromes such as Familial Adenomatous Polyposis (FAP) or Hereditary Non-Polyposis Colorectal Cancer (HPNCC).

At least 75% of program funds budgeted for screening services should be spent on screening individuals at average risk

b. Increased Risk

People at increased risk for CRC may be eligible for CRC screening or surveillance. People at increased risk for CRC include those with:

- A personal history of adenomatous polyps on a previous colonoscopy
- A personal history of colorectal cancer
- A family history of CRC or adenomatous polyps

People at increased risk for CRC due to a personal history of adenomatous polyps or colorectal cancer are eligible for surveillance with colonoscopy only.

c. High Risk

People at high risk for CRC are not eligible for screening or surveillance services through the MCCP. People at high risk for CRC include those with:

- A genetic diagnosis of familial adenomatous polyposis (FAP) or hereditary non-polyposis colorectal cancer (HNPCC).
- A clinical diagnosis or suspicion of FAP or HNPCC.
- A history of inflammatory bowel disease (ulcerative colitis or Crohn's disease).

People at high risk for CRC generally require genetic counseling and/or intensive clinical and surveillance services that are beyond the scope of this program.

People at high risk for CRC who present to the program for screening or surveillance services must be referred for appropriate services. Contractors will refer clients to other privately or publicly funded programs in their multi-county area.

d. Gastrointestinal symptoms

People with significant gastrointestinal symptoms are not eligible for screening services through the MCCP. Symptoms that would preclude eligibility for the program include, but are not limited to:

- Rectal bleeding, bloody diarrhea or blood in the stool within the past 6 months (bleeding that is known or suspected to be due to hemorrhoids after clinical evaluation would not prevent a client from receiving CRC screening services).
- Prolonged change in bowel habits (e.g., diarrhea or constipation for more than two weeks that has not been clinically evaluated).
- Persistent abdominal pain.
- Symptoms of bowel obstruction (e.g., abdominal distension, nausea, vomiting, severe constipation).
- Significant unintentional weight loss of 10% or more of starting body weight.

By definition, screening for colorectal cancer is testing for the presence of colorectal cancer or cancer precursors in the absence of symptoms. While gastrointestinal symptoms may be indicative of an underlying colorectal cancer or polyp, they may also be caused by many other conditions. People presenting with these symptoms need a complete evaluation by a clinician to determine the cause of their symptoms. This evaluation and any potential subsequent treatment, is beyond the scope of this program. If a client has been medically evaluated and cleared for colorectal cancer screening, then the client may enroll in the program if all eligibility criteria are met.

When clients present with minor symptoms that may not preclude enrollment in the program, the program should consult with the medical service provider to determine if the client can be enrolled in the program or if the client should be referred for clinical evaluation. Contractors will refer clients to other privately or publicly funded programs in their multi-county area.

C. Reporting Systems

1. Colorectal Screening and Diagnostic Tests

We recommend endoscopists follow the standardized colonoscopy reporting and data system (CO-RADS). [Gastrointest Endosc. 2007 May;65(6):757-66]

D. Quality Assurance

1. Clients with positive or abnormal screening tests must receive appropriate diagnostic procedures as determined by the program and the MAB. Clients with a positive or abnormal FOBT must receive a complete colon examination with colonoscopy.

2. Clients diagnosed with colorectal cancer or other cancers or medical conditions, must be referred for appropriate treatment. The Commission on Cancer approved facilities in Montana will see clients diagnosed in the MCCP in their indigent care program.

3. The interval between initial screening and diagnosis of positive or abnormal screening results should be 90 days or less.

4. The interval between diagnosis and initiation of treatment for colorectal cancer should be 60 days or less.

5. Inadequate Bowel Prep:
   a. for screening or diagnostic colonoscopy: proceed as per endoscopist
      - Schedule repeat colonoscopy (covered by this program) with same bowel prep or alternative prep used (covered by this program) OR
      - Schedule for Double Contrast Barium Enema (covered by this program)
      - Requests for exceptions will be considered on a case by case basis

6. Failure to reach the cecum:
   a. For screening colonoscopy: proceed as per endoscopist.
      - Schedule for repeat colonoscopy at interval per endoscopist (covered by this program). OR
      - When at least the splenic flexure is reached, consider the screening test as a flexible sigmoidoscopy and schedule for repeat endoscopy in 5 years (covered by this program) plus an interval high-sensitivity FOBT/FIT every 3years (covered by this program).
      - Requests for exceptions will be considered on a case by case basis.

   b. For diagnostic colonoscopy: proceed as per endoscopist.
      - Schedule for repeat colonoscopy at interval per endoscopist (covered by this program). OR
      - Schedule for Double-Contrast Barium Enema (covered by this program)
        Note: CT colonography not covered by this program.
      - Requests for exceptions will be considered on a case by case basis.

7. Clients who have limited life expectancy as determined by the medical service provider may not benefit from screening. (The benefit from screening is not seen in trials until at least seven years later). Contractors should facilitate opportunity for discussion between the client and the medical service provider to establish an individual management plan.

8. Summary of Quality Indicators

Proposed Indicator Type, Number and Description			**CDC Benchmark**
Screening Priority Population	1	Percent of new clients screened who are at average risk for CRC	≥ 75%
	2	Percent of average risk new clients screened who are aged 50 years and older	≥ 95%
Completeness of Clinical Follow-up	3	Percent of abnormal test results with diagnostic follow-up completed	≥ 90%
	4	Percent of diagnosed cancers with treatment initiated	≥ 90%
Timeliness of Clinical Follow-up	5	Percent of positive tests (FOBT/FIT) followed-up with colonoscopy within 90 days	≥ 80%
	6	Percent of cancers diagnosed with treatment initiated within 60 days	≥ 80%

E. Reporting of Complications

Medical complications experienced by clients who have received an endoscopy (colonoscopy) during or within 30 days after the procedure, must be reported to the MCCP manager. Confirmed complications that result in an emergency room visit, hospitalization or death will be reported to the CDC by the state office.

F. Screening Adherence

Before considering that a client is not going to return the fecal test, the cancer control specialist must:

- Make three attempts to contact a client. The first two attempts may be by phone or writing. The third or final attempt must be a letter sent by certified mail with a return receipt requested.
- Complete all attempts to contact a client within 6 weeks of client receiving fecal test from provider.

Before considering that a client is not going to complete colonoscopy screening, the cancer control specialist must:

- Reschedule the client three times for the colonoscopy.
- After the third time consider the test not done.

CRC Screening Algorithm Appendix

Appendix A: Eligibility for Enrollment

1. Limited life expectancy

   If limited life expectancy is determined by the primary care provider, screening may not be appropriate. Keep in mind the benefit of screening is not seen in trials until at least 7 years later. http://www.ahrq.gov/clinic/uspstf08/colocancer/colors.htm#clinical

2. Symptoms of serious GI disease

   Screening is checking for disease when there are no symptoms. For this screening program, average risk persons are those with no symptoms suggestive of gastrointestinal disease or colorectal cancer (CRC). Potential clients who are symptomatic at enrollment are not eligible for this program and will be referred for medical evaluation outside of the program. Educational materials, Medicaid/Medicare information and regional provider contact information will be supplied to the individual.

The following are symptoms of CRC. These symptoms can also be associated with many other health conditions such as infection, hemorrhoids or inflammatory bowel disease.

- Rectal bleeding, dark stools or blood in or on the stool.
- Change in bowel habits, such as diarrhea, constipation or narrowing of the stool that lasts for more than a few days.
- General, unexplained stomach discomfort.
- Feeling you need to have a bowel movement that is not relieved by doing so.
- Cramping or abdominal (stomach area) pain.
- Weakness and fatigue.
- Unexplained weight loss.

References:

ACS:
http://www.cancer.org/docroot/CRI/content/CRI_2_6X_Colorectal_Cancer_Early_Detection_10.asp?from=colontesting

CDC:
http://www.cdc.gov/cancer/colorectal/basic_info/symptoms.htm

Appendix B: High Sensitivity FIT or FOBT

CDC recognizes the following tests as High Sensitivity:

- FOBT = Hemoccult Sensa™
- FIT = Hemoccult ICT™, Insure™ or Polymedco/Eiken

Rationale: For this grant program, the CDC requires that the program follows USPSTF recommendations for CRC screening.

Supporting articles for USPSTF October 2008 “CRC Screening Recommendations” support the use of high sensitivity FOBT/FIT. Screening programs incorporating fecal occult blood testing, sigmoidoscopy or colonoscopy will all be effective in reducing mortality. Although use of an annual fecal occult blood screening test with a lower sensitivity (Hemocult II™) has been demonstrated to reduce colorectal cancer mortality in randomized controlled trials, modeling suggests that the number of life-years gained will be greater with the strategies using higher-

sensitivity tests. Modeling evidence suggests that population screening programs targeting people between the ages of 50 and 75 years using any of the following 3 regimens will be approximately equally effective in life-years gained, assuming 100% adherence to the same regimen for that period: 1) annual high-sensitivity fecal occult blood testing, 2) sigmoidoscopy every 5 years combined with high-sensitivity fecal occult blood testing every 3 years and 3) screening colonoscopy at intervals of 10 years. Use of annual high-sensitivity fecal occult blood testing (sensitivity for cancer>70%; specificity>90%), is estimated to require the fewest colonoscopies while achieving a gain in life-years similar to that seen with screening colonoscopy every 10 years.

Use of high-sensitivity fecal blood tests is also recommended by "Screening and Surveillance for the Early Detection of Colorectal Cancer and Adenomatous Polyps, 2008: A Joint Guideline". The expert panel for this article reports FIT that are high sensitivity include: Magstream 1000™, Hemoccult ICT™, and Insure™.

This program will cover the use of either high-sensitivity FOBT/FIT or colonoscopy for CRC screening.

References:

USPSTF:
http://www.ahrq.gov/clinic/uspstf08/colocancer/colors.htm
http://www.ahrq.gov/clinic/uspstf08/colocancer/coloartwhit.htm
http://www.ahrq.gov/clinic/uspstf08/colocancer/coloartzaub.htm

Screening and Surveillance for the Early Detection of Colorectal Cancer and Adenomatous Polyps, 2008: A Joint Guideline:
http://caonline.amcancersoc.org/cgi/content/full/CA.2007.0018v1

Appendix C: Increased Risk Category

Individuals are at increased risk for colorectal cancer if they have a personal history of colorectal cancer or polyps or if there is a family history of colorectal cancer. Clients eligible for enrollment, assessed to have increased risk will, be offered a screening or surveillance colonoscopy as recommended in the following table from the American Cancer Society's "Guidelines for Screening and Surveillance for the Early Detection of Colorectal Adenomas and Cancer in Individuals at Increased Risk". Individual cases will be reviewed upon request prospectively if a different schedule is proposed by a participating provider.

Guidelines for Screening and Surveillance for the Early Detection of Colorectal Adenomas and Cancer in Individuals at Increased Risk			
Risk Category	Age To Begin	Recommendation	Comment
Increased risk -- Patients With a History of Polyps on Prior Colonoscopy			
People with small rectal hyperplastic polyps	Same as those with average risk	Colonoscopy or other screening options at regular intervals as for those at average risk	Those with hyperplastic polyposis syndrome are at increased risk for adenomatous polyps and cancer and should have more intensive follow-up.
People with 1 or 2 small (less than 1 cm) tubular adenomas with low-grade dysplasia	5 to 10 years after the polyps are removed	Colonoscopy	Time between tests should be based on other factors such as prior colonoscopy findings, family history and patient and doctor preferences.
People with 3 to 10 adenomas or a large (1 cm +) adenoma or any adenomas with high-grade dysplasia or villous features	3 years after the polyps are removed	Colonoscopy	Adenomas must have been completely removed. If colonoscopy is normal or shows only 1 or 2 small tubular adenomas with low-grade dysplasia, future colonoscopies can be done every 5 years.
People with more than 10 adenomas on a single exam	Within 3 years after the polyps are removed	Colonoscopy	Doctor should consider possibility of genetic syndrome (such as FAP or HNPCC).
People with sessile adenomas that are removed in pieces	2 to 6 months after adenoma removal	Colonoscopy	If entire adenoma has been removed, further testing should be based on doctor's judgment

Guidelines for Screening and Surveillance for the Early Detection of Colorectal Adenomas and Cancer in Individuals at Increased Risk			
Risk Category	Age To Begin	Recommendation	Comment
Increased Risk – Patients With Colorectal Cancer			
People diagnosed with colon or rectal cancer	At time of colorectal surgery or can be 3 to 6 months later if person doesn't have cancer spread that can't be removed	Colonoscopy to view entire colon and remove all polyps	If the tumor presses on the colon/rectum and prevents colonoscopy, CT colonoscopy (with IV contrast) or DCBE may be done to look at the rest of the colon.
People who have had colon or rectal cancer removed by surgery	Within 1 year after cancer resection (or 1 year after colonoscopy to make sure the rest of the colon/rectum was clear)	Colonoscopy	If normal, repeat exam in 3 years. If normal then, repeat exam every 5 years. Time between tests may be shorter if polyps are found or there is reason to suspect HNPCC. After low anterior resection for rectal cancer, exams of the rectum may be done every 3 to 6 months for the first 2 to 3 years to look for signs of recurrence.

Guidelines for Screening and Surveillance for the Early Detection of Colorectal Adenomas and Cancer in Individuals at Increased Risk			
Risk Category	Age To Begin	Recommendation	Comment
Increased Risk – Patients With a Family History			
Colorectal cancer or adenomatous polyps in any first-degree relative before age 60 or in 2 or more first-degree relatives at any age (if not a hereditary syndrome).	Age 40 or 10 years before the youngest case in the immediate family, whichever is earlier	Colonoscopy	Every 5 years.
Colorectal cancer or adenomatous polyps in any first-degree relative aged 60 or higher or in at least 2 second-degree relatives at any age	Age 40	Same options as for those at average risk.	Same intervals as for those at average risk.

Reference:

http://www.cancer.org/docroot/CRI/content/CRI_2_4_3X_Can_colon_and_rectum_cancer_be_found_early.asp?sitearea=PRO#table

Appendix D: Genetic syndromes or Inflammatory Bowel Disease

Potential clients who have been diagnosed or have symptoms compatible with Inflammatory Bowel Disease (IBD) or known or family history suggestive of Genetic Syndromes are not eligible for this program. They will be referred for appropriate medical care or evaluation outside of the program. Educational materials, Medicaid/Medicare information, genetic testing/counseling and appropriate regional provider contact information will be supplied to the individual. Clients found by genetic testing to be negative may return for CRC screening.

- Inflammatory Bowel Disease
  - Ulcerative Colitis: A relatively common disease that causes inflammation of the large intestine. The cause is unknown. Intermittent rectal bleeding, crampy abdominal pain and diarrhea can be symptoms of ulcerative colitis. Ulcerative colitis characteristically waxes and wanes.
  - Crohn's Disease: A chronic inflammatory disease of the intestines. It primarily causes ulcerations of the small and large intestines, but can affect the digestive system anywhere from the mouth to the anus. The cause of Crohn's disease is unknown. Common symptoms of Crohn's disease include abdominal pain, diarrhea and weight loss. Less common symptoms include poor appetite, fever, night sweats, rectal pain and rectal bleeding. The symptoms of Crohn's disease are dependent on the location, the extent and the severity of the inflammation. Anal fistulae and peri-rectal abscesses also can occur.

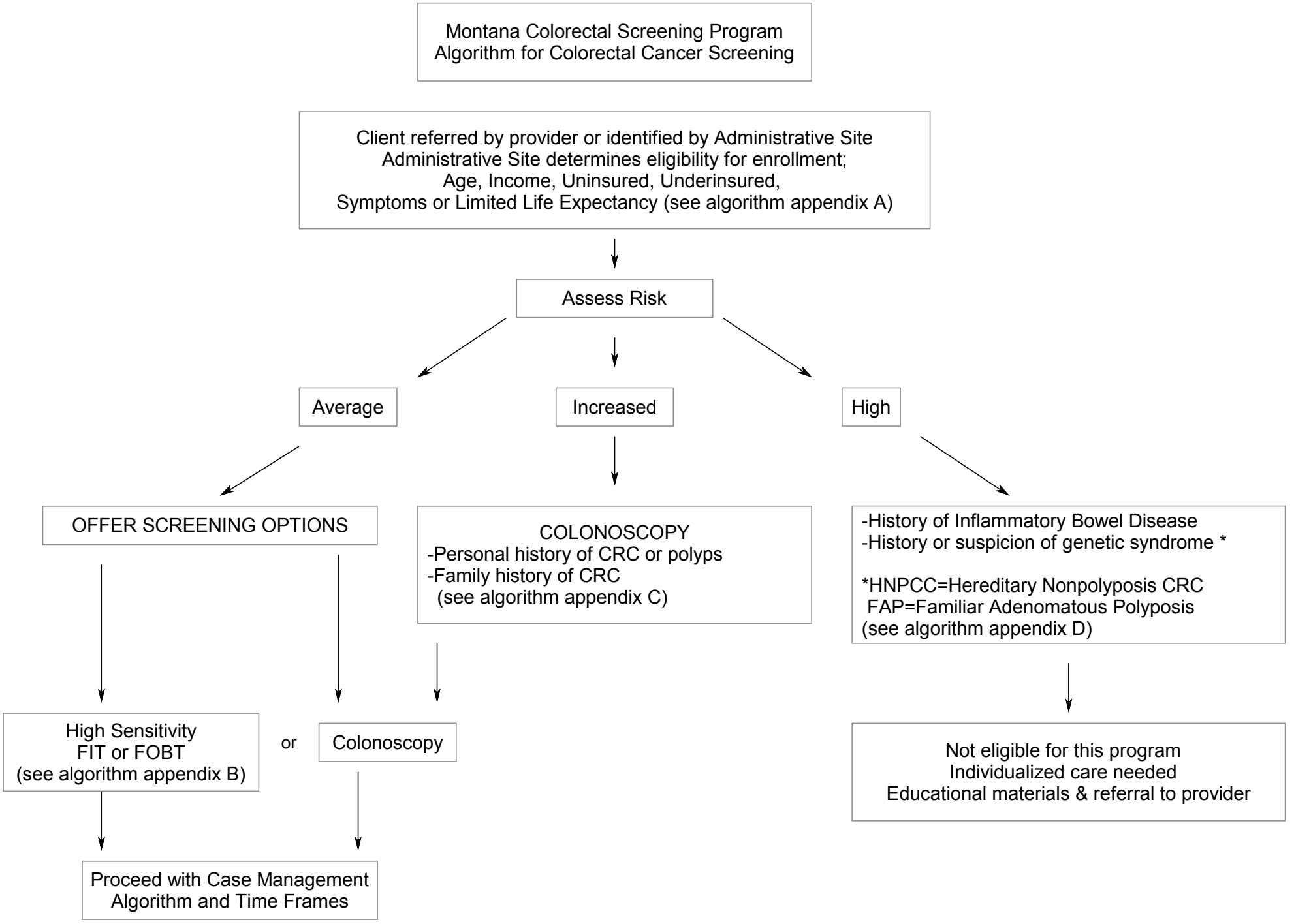
  Reference:

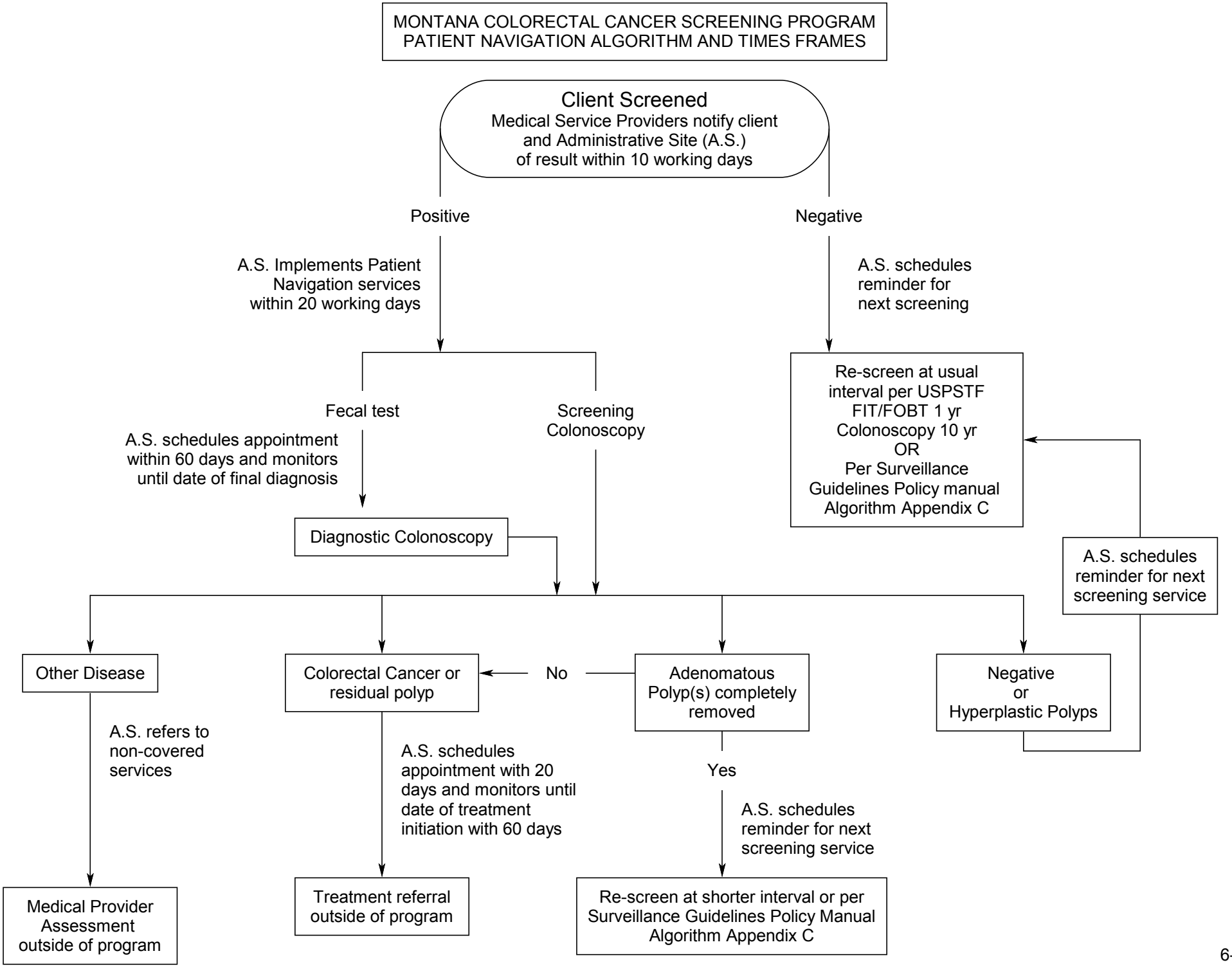
  http://www.medicinenet.com

- Genetic Syndromes
  - Hereditary Nonpolyposis Colorectal Cancer (HNPCC or Lynch syndrome) is the most common type of genetic colorectal cancer. It accounts for about 2 percent of all colorectal cancer cases. HNPCC is characterized by a risk of colorectal cancer and other cancers of the endometrium, ovary, stomach, small intestine, hepatobiliary tract, upper urinary tract, brain and skin. The increased risk for these cancers is due to autosomal dominant pattern inherited mutations in an HNPCC gene that impair DNA mismatch repair. Most people with these changes in the HNPCC gene develop colorectal cancer and the average age at diagnosis is 44.
  - Familial Adenomatous Polyposis (FAP) is a rare, genetic disease in which hundreds of polyps form in the colon and rectum. FAP can have different inheritance patterns and different genetic causes. When it is caused by a change in a gene called APC, it is inherited in an autosomal dominant pattern. Unless FAP is treated, it usually leads to colorectal cancer by age 40. FAP accounts for less than 1 percent of all colorectal cancer cases.

  References:

  http://www.cancer.gov/colorectalcancerrisk/colorectal-cancer-risk.aspx
  http://en.wikipedia.org/wiki/Familial_adenomatous_polyposis#Genetics
  http://en.wikipedia.org/wiki/Hereditary_nonpolyposis_colorectal_cancer


Montana Colorectal Screening Program
Algorithm for Colorectal Cancer Screening
Client referred by provider or identified by Administrative Site
Administrative Site determines eligibility for enrollment;
Age, Income, Uninsured, Underinsured,
Symptoms or Limited Life Expectancy (see algorithm appendix A)
Assess Risk
Average
Increased
High
OFFER SCREENING OPTIONS
COLONOSCOPY
-Personal history of CRC or polyps
-Family history of CRC
(see algorithm appendix C)
-History of Inflammatory Bowel Disease
-History or suspicion of genetic syndrome *
*HNPCC=Hereditary Nonpolyposis CRC
FAP=Familiar Adenomatous Polyposis
(see algorithm appendix D)
High Sensitivity
FIT or FOBT
(see algorithm appendix B)
or
Colonoscopy
Not eligible for this program
Individualized care needed
Educational materials & referral to provider
Proceed with Case Management
Algorithm and Time Frames


MONTANA COLORECTAL CANCER SCREENING PROGRAM
PATIENT NAVIGATION ALGORITHM AND TIMES FRAMES
Client Screened
Medical Service Providers notify client and Administrative Site (A.S.) of result within 10 working days
Positive
Negative
A.S. Implements Patient Navigation services within 20 working days
A.S. schedules reminder for next screening
Fecal test
Screening Colonoscopy
A.S. schedules appointment within 60 days and monitors until date of final diagnosis
Re-screen at usual interval per USPSTF FIT/FOBT 1 yr Colonoscopy 10 yr OR Per Surveillance Guidelines Policy manual Algorithm Appendix C
Diagnostic Colonoscopy
A.S. schedules reminder for next screening service
Other Disease
Colorectal Cancer or residual polyp
No
Adenomatous Polyp(s) completely removed
Negative or Hyperplastic Polyps
A.S. refers to non-covered services
A.S. schedules appointment with 20 days and monitors until date of treatment initiation with 60 days
Yes
A.S. schedules reminder for next screening service
Medical Provider Assessment outside of program
Treatment referral outside of program
Re-screen at shorter interval or per Surveillance Guidelines Policy Manual Algorithm Appendix C

7 COALITIONS, OUTREACH AND SYSTEMS CHANGE

A. Regional Coalitions

The cancer control specialist must build and maintain one or more regional comprehensive cancer coalitions to develop, help implement, revise and evaluate cancer control and screening activities.

The cancer control specialist must:

- Ensure that coalitions meet on a quarterly basis.
- Identify and accomplish regional activities to strengthen community capacity and support development of evidenced based cancer control programs consistent with the Montana Comprehensive Cancer Control Plan priorities.
- Track attendance.
- Prepare and distribute written summaries to all involved and interested parties.
- Continually recruit a professional and regional diverse membership.
- Identify resources available in the multi-county area for screening program clients who need diagnostic tests and treatment services not reimbursable by MCCP and for clients in need of services who are not MCCP eligible.

1. How can a coalition create community change?

- It allows organizations to become involved in new and broader issues without having the sole responsibility for managing or developing those issues.
- It demonstrates and develops widespread public support for issues, actions or unmet needs.
- It maximizes the power of individuals and groups through joint actions.
- It minimizes duplication of effort and services.
- It improves trust and communication among groups that would normally compete with one another.
- It helps mobilize more talents, resources and approaches to an issue than any single organization could achieve alone.
- Its flexible nature helps it to exploit new resources in changing situations.

2. How is a healthy, active coalition launched?

- **Assemble a core planning group**
  Bring together enough of the right people who have a common interest around the issue or need and are willing to meet regularly to plan for their community.

- **Discuss the health problem or needs to be addressed**
  Discussions need to produce agreement on the health problems or needs of the community. The group must develop a clear understanding of the issues and a consensus of the need for action.

- **Clarify the group's mission and priority issues**
  Group members need to see themselves working towards a common goal and should be able to describe the mission in a few short words.

- **Identify priority populations and interventions most likely to succeed**
  Based on data and collective wisdom, target populations and possible interventions should be discussed. Partners will want to include representatives from the identified audience in the coalition membership.

- **Identify and recruit additional partners**
  Consider who else should be at the table and if the group is strong enough with the current members. It is important to recruit representatives from as many segments of the community as possible. Diverse representation will strengthen your planning and implementation. Have current members invite new members to participate.

- **Choose a leader and define member roles**
  It is necessary to designate group leadership. Initial leadership should come from the core planning group. The group can also elect co-leaders to divide the leadership role. It is also important to define individual members' jobs. Individual members can be more successful if they are empowered to work on their defined role outside of a group setting and make some of their own decisions. For example, establishing workgroups within the coalition, i.e. recruitment, outreach, fundraising, etc.

- **Develop a work plan to address priority issues**
  As a team, write a work plan to reach your designated audience with the interventions most likely to succeed. The work plan should include specific measurable objectives. Each objective should then have detailed action steps with a defined timeframe and a member assigned to oversee each action step. The work plan can also list out resources the coalition will need to obtain, such as funding or materials.

- **Work to build involvement, ownership and consensus**
  Active involvement by members is critical. However, it may take some time for team members to get involved and feel connected to the team. Training about health promotion and project goals will help members feel more confident of their participation and decision-making. Work to involve all members and when possible, proceed with group consensus.

- **Implement the work plan through the full partnership or through designated work groups**
  The work plan is a working document for implementing interventions and can be adapted as needed. If the coalition has a narrowly defined mission, it may work well to plan and implement the work plan as a full group. But if your mission is more broad-based and the partnership has several priority issues, it may be more effective to divide into work groups.

- **Provide the coalition enough structure to continue and grow**
  Coalitions vary from formal to informal working structures. Some coalitions function better with formalized by-laws and organizational structure. Others function more effectively with an informal structure. Adopt a structure that meets the needs of group members and the task at hand. Do not overlook that a method for maintaining leadership and members will be essential for a coalition to continue and grow.

B. American Indian Outreach

The Montana American Indian Women's Health Coalition (MAIWHC) is funded through the MCCP as part of a statewide program to promote cancer screening services on seven reservations, Little Shell Chippewa Tribe and five urban centers in Montana. MAIWHC is made up of community and professional American Indian women whose purpose is to guide and assist the MCCP with the American Indian Screening Initiative.

Cancer control specialists in cooperation with the American Indian screening coordinator (AISC) and MAIWHC members will develop and implement community-based and interpersonal education and outreach efforts for their respective regions. To assist with outreach to American Indian people, a screening event protocol has been established and is listed below:

1. Purpose of a Screening Event

To increase the number of American Indian people screened for breast, cervical and colorectal cancer through the Montana Cancer Control Programs (MCCP).

2. Planning is the key to success

A cancer control specialist may initiate a plan for a specific event or may be invited to participate in an event that is being planned by a local coalition or clinic staff.

The cancer control specialist should:

- First, contact the AISC when initiating the plan or immediately after being invited to participate in an event.
- The MCCP AISC will work with the cancer control specialist to ensure MCCP collaboration and support.
- Involve local coalitions and/or MAIWHC members in the screening event as volunteers and resource personnel.

3. Contact the AISC for a work plan and budget template.

- The plan and budget must be submitted at least one (1) month prior to the event for review and approval before the AISC can commit MCCP resources.
- An evaluation report of the event will be due to the AISC one (1) month after the event.
- Work plan elements that must be included are:
  - Any facilities that will be involved. Is there an expense or in-kind donation?
  - Date of planned event.
  - All staff involved and their duties. Include professional staff and any other staff resources that will be needed. (Is the provider enrolled? Will the facility be staffed? Will the Mammography tech be present on the day of the event?)
  - The number of people who will receive services.
  - How will people be recruited or invited to the event?
  - How will the staff at the event ensure client confidentiality?
  - How will screening results be released to the client's primary care provider and how will the client be informed?
- How will the MCCP data collection forms be completed, signed and sent to the cancer control specialist?
- How will the follow-up and case management of abnormal test results be completed in a timely manner?
- What is the plan to contact people who are not residents in the immediate area? (Pow-wow participants, out-of-state clients).
- What is the plan (if needed) for transportation of MCCP clients?
- What is the plan for media coverage of the event? (Before, during and after the event.)
- How will the event be evaluated?

4. Suggestions to make the event more successful:

- Identify and enroll MCCP eligible people prior to the event if possible.
- Make sure there are alternative funding sources for people who are not MCCP eligible. For example IHS or contract health funds, Medicaid or donated services.
- Use this setting to inform and educate people of all ages. Promoting preventive wellness and a safe environment to access services. Invite other health promotion organizations to participate. Offer a variety of health-related information.
- Offer a planned activity for people while they are waiting to be screened.
- Offer incentives for completed screens.
- Have clients and providers evaluate the screening event to identify quality of care issues and efficiency of routing process.

5. **Suggestions for the use of MCCP resources. These and other items that may be considered for both real and in kind expenses:**

   - Supplies and services (mobile mammography).
   - Personnel to help with the logistics, registration etc.
   - Travel for clients to and from the event.
   - Incentives and other expenses such as brochures, posters, announcements.

6. **The evaluation and report of the screening event should include:**

   - The number of MCCP eligible people screened during the event.
   - The number of people who are appointed or partially completed. Briefly document the plan to complete the services. Document the plan to complete tracking and follow-up for abnormal test results.
   - The total number of people who received breast, cervical and colorectal health education.
   - The total of expenses including in-kind from other sources. Expenses will be reconciled with the budget and invoices before payment is made.
   - Identify what went well and what was challenging.
   - Identify education and training needs for the local providers that can enhance future events.

C. Public Education and Outreach

The cancer control specialist will contribute to the implementation of the Montana CCC Plan through advocacy and educational activities related to current state and regional comprehensive cancer control issues. Cancer control activities must be evidence-based and focus on changing behavior.

Specific activities will be defined in the cancer control specialist's regional work plan and include the following:

- Develop a relationship with the local media to respond to inaccurate health information in the media in relation to MCCP and proactively feed MCCP stories to the media. Media outlets can include TV, print or radio.
- Implement targeted small media campaigns to facilitate increased breast, cervical and colorectal cancer screening rates in all populations in the multi-county area.
- Assist Montana Tobacco Use Prevention Program (MTUPP) and Nutrition and Physical Activity Program (NAPA) in their efforts to reduce tobacco use and improve nutrition and physical activity respectively to maximize resources and reduce duplication of efforts. Partnering activities should be led by partner organizations with support from the cancer control specialist.

D. Policy and Systems Change

Policy and systems change focuses on activities that are sustainable and impact groups of people rather than one-on-one behavior change. Cancer control specialists will work to leverage existing resources and infrastructure to increase screening in the general population. Specific activities will be defined in the cancer control specialist's regional work plan and include the following:

1. Partner with two (2) organizations or systems to achieve increased breast, cervical and colorectal cancer screening rates in the general population by implementing at least two (2) of the following activities in each site:
    - Encourage coverage and/or expanded benefits for cancer screening.
    - Encourage adoption of policies that support preventive care (e.g. time off for cancer screening).
    - Support adoption/expansion of wellness program.
    - Increase awareness of the need and benefits of cancer screening.

    When assessing an organization or system to partner with consider the following:
    - Does the organization serve our screening target populations or a sub-group within the target populations?
    - Does the organization see cancer as an issue?
    - Do they already have health-related activities in place?
    - Are they willing to partner with you on a health-related activity?

2. Increase colorectal screening by assisting provider offices in implementing the CRC clinicians toolbox: *How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician's Evidence-Based Toolbox and Guide.* The Toolbox addresses Four Essentials for improving screening rates: a physician recommendation, an office policy, an office reminder system and an effective communication system. Cancer control specialists will provide support and technical assistance to local physician offices to implement the Toolbox. The Toolbox basics are listed below. For detailed process and steps refer to the full Toolbox document.

    - Physician recommendation:
        - There is well established evidence for the influence of a physician's recommendation on the cancer screening decisions of their patients.
        - Physician recommendation is the most powerful influence on individual patient decisions to undergo cancer screening.
        - To provide the correct screening recommendation for CRC, the physician needs to be up-to-date on the current screening guidelines.
        - To make use of the physician recommendation evidence, a clinician should recommend screening at every opportunity. And the clinician needs to not only provide the screening recommendation but follow through on screening results and refer for diagnostic testing if need be.

- Office Policy:
  - Along with the physician recommendation, a systematic approach is needed to ensure that all eligible patients leave their visit with a screening recommendation.
  - Office policies are the foundation of a systematic approach. Policies do not need to be the same in every office but just need to exist in some form.
  - A policy should include:
    - A risk assessment tool to determine the recommended screening options for each patient.
    - Offices should be aware of local medical resources for screening options that are realistic and accessible for the patients.
    - Differences in coverage for screening options, deductibles, co-pays and un-insured patients.
    - Involve the patient in the decision making process. Share decision-making between the patient and clinician, including discussion of patient screening preference.
  - The office policy will be unique to each setting. It does not need to include all screening options, the office can choose what to offer based on recommendations and resources available. A policy should outline a step-by-step procedure to screen for CRC.

- Office reminder system:
  - For patients, reminders both educate and instigate action. Using theory based (stages of change, health belief model) education and having the education take place actively (phone or in person) rather than passively (generic postcard) has the most effect on increasing screening. Patient prompts provided throughout the office visit from the time they walk through the door to the time they leave and calls to remind them for follow-up are examples of active reminders.
  - All provider focused intervention strategies have been documented to be effective in raising screening rates.
  - Chart prompts: There is no substitute for a visual prompt to focus provider attention at the right moment.
  - Audits and Feedback: While time consuming, collecting this information is not complicated and is essential for maintaining the quality of practice.
  - Ticklers and logs: A tickler system is organized by test completed. The office staff waits for results and follows-up appropriately. Log sheets record information of all patients who have had the same test. The office staff waits for results and follows-up appropriately.
  - Staff assignments: Staff can help boost screening rates by encouraging screening or initiating the process.

- Effective communication system:
  - The final essential in the toolbox is an effective communication system. Communication tools and systems can convey clear advice to screen without increasing the time pressure on the physician-patient encounter.
  - The right information at the right time is the communication that will make a difference. The stages of change theory tailors messages to where a person is at on the scale of readiness to change their behavior: pre-contemplation, contemplation, action and maintenance.
  - Physicians and office staff should aim for shared decision with the patient about screening options.
  - When staff are explicitly involved in making practice improvements, it becomes easier to achieve the desired goals.

3. Support and track local-level policy changes regarding important cancer control outcomes including physical activity, nutrition, tobacco, screening, tanning, insurance coverage and professional education.

E. Provider Education

Cancer control specialists work closely with medical service providers to increase cancer screening rates. It is important to maintain communication with these medical providers and keep them updated on current cancer screening information.

- Educate medical service providers on MCCP screening services, the importance of physician recommendation for cancer screenings and that the insured population is not utilizing screening benefits.
- Provide screening enrollment packets and instructions for completion to each interested medical service provider.
- Provide at least one (1) orientation program to each medical service provider in the multi-county area, through group or individual offerings.
- Provide each enrolled medical service provider a reference to www.cancer.mt.gov for a current MCCP PPM and/or updates.

8 CONTRACTOR REPORTING REQUIREMENTS

A. Reporting and Communication

Cancer control specialists must:

- Submit clinical data to the MCCP office using the site data system.
- Submit a proposed one year work plan to further implement MCCP activities by July 10th.
- Submit quarterly and final progress reports related to work plan activities by October 10th, January 10th, April 10th and July 10th.
- Participate in all telephone consultations, on-site visits and program evaluation activities.
- Provide documentation of supplemental program resources received through in-kind and monetary contributions using the in-kind form provided in the MCCP PPM. Submit completed in-kind form with quarterly reports.
    - In-kind funds include, but are not limited to: donated rent, administrative or indirect charges, volunteer time, staff time, communication expenses and computer access.
    - Other non-federal funds documented could include: community funds, indigent funds, United Way contributions, local grants, treatment funds or other non-federal funding available for breast, cervical, colorectal cancer screening and health education.

B. Record Maintenance

The cancer control specialist is responsible for keeping a client file for every Cancer Screening Program participant including an “Informed Consent and Authorization to Disclose Health Care Information” form and all completed MCCP data collection forms. The file must be confidential, secured by lock when not in use and be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) regulations.

C. Record Retention

To comply with MCCP record retention and audit requirements, cancer control specialists must retain all client records for a period of not less than five (5) years from the date of the last entry made in the client record.

D. Payment for Task Order Work Completed

The MCCP office will send a Payment Summary document by confidential fax that lists clients served through the screening program during the quarter time period. The cancer control specialist will review and submit corrections or approve the Payment Summary.

1. If the Payment Summary is COMPLETE and ACCURATE:

- The cancer control specialist or contract liaison will sign and date the signature page.
- Return the signature page to the MCCP state office by confidential fax.

2. If the Payment Summary is NOT COMPLETE or is INACCURATE:

- Write the corrections on the Payment Summary. Remember clients may not be on the payment summary if the:
    - screening cycle is pending.
    - case is not eligible for patient navigation.
    - client was paid in a previous cycle.
- Return the corrected Payment Summary to the MCCP state office. Mark the first page "corrected". Do not sign or initial the last page.
- The MCCP state office will review the suggested corrections.
    - If agreed upon, a corrected Payment Summary will be sent for signature.
    - If not agreed upon, an explanation will be returned.

Timely payment is contingent upon:

- Work plan quarterly report being submitted and approved by MCCP staff.
- Payment summary being reviewed, signed and returned to the MCCP office.

Due dates:

- Payment summary sent by MCCP to regional contractor: October 5th, January 5th, April 5th and July 5th
- Cancer control specialist submits signed payment summary or corrections to payment summary to state office by: October 10th, January 10th, April 10th and July 10th.
- Payment will be processed by MCCP by: October 30th, January 30th, April 30th and July 30th.

A final end of year Payment Summary will be sent by August 15th. The cancer control specialist will have until the August 20th to review, submit corrections or approve the Payment Summary. The MCCP office will process the final payment by August 31st.

E. Work Plans

The cancer control specialist must submit a proposed one year work plan by July 10th of each year. The approved work plan will be followed over the course of the year to further implement MCCP activities.

- The work plan is submitted at the end of each quarter as a cumulative record of work performed.
- Any required supporting documentation to be included with quarterly report (coalition minutes, copies of articles, educational materials, etc.) is listed in the supporting documentation column of the work plan.
- Additional optional activities will need to be evidence-based.
- Screening numbers are reported through the site data system and are not included on the work plan.

☐Qtr 1 Due: 10/10/10 ☐ Qtr 2 Due: 01/10/11 ☐ Qtr 3 Due: 04/10/11 ☐Qtr 4 Due: 07/10/11

DELIVERABLE #5: REGIONAL COALITIONS		
Deliverables	**Supporting Documentation**	**Quarterly Progress**
Ensure that coalition(s) meet at least once per quarter; track attendance.	Meeting agendas and/or meeting minutes	Q1 Q2 Q3 Q4
Collect input from the coalition(s) on the Contractor's work plan.	Agenda topics and meeting minutes	Q1 Q2 Q3 Q4
Include coalition members in accomplishing at least four (4) work plan objectives as demonstrated in the key partners assigned column on the work plan.	Lead personnel and key partners assigned to activities in Deliverable 6	Q1 Q2 Q3 Q4
Continually recruit a professionally and regionally diverse membership from each county in the Contractor's multi-county area.	Coalition roster to include town names and professional or personal affiliation	Q1 Q2 Q3 Q4

DELIVERABLE #6: PUBLIC EDUCATION				
Deliverables	**Supporting Documentation**	**Lead Personnel Assigned**	**Key Partners Assigned**	**Quarterly Progress**
Respond to inaccurate health information in the media in relation to cancer control.	Copies of stories, articles, interviews, ads			Q1 Q2 Q3 Q4
Two (2) "stories/articles published" through the contract period.	Copies of stories, articles, interviews, ads			Q1 Q2 Q3 Q4

DELIVERABLE #6: PUBLIC EDUCATION

Targeted Small Media Campaigns
Two (2) targeted small media campaigns during the contract period to facilitate increased breast, cervical, and colorectal cancer screening rates in the general population in the multi-county area.

CAMPAIGN 1

What Will be Measured	Documentation/ Data Source(s)	Baseline & Target	Direction of Change	Completion Date
			Increase, decrease or maintain	

Activities for Campaign 1	Lead Personnel Assigned	Key Partners Assigned	Quarterly Progress
			Q1 Q2 Q3 Q4

CAMPAIGN 2

What Will be Measured	Documentation/ Data Source(s)	Baseline & Target	Direction of Change	Completion Date
			Increase, decrease or maintain	

Activities for Campaign 2	Lead Personnel Assigned	Key Partners Assigned	Quarterly Progress
			Q1 Q2 Q3 Q4

DELIVERABLE #6: PUBLIC EDUCATION

Partner Activity with MTUPP
Assist Montana Tobacco Use Prevention Program (MTUPP) in their efforts to reduce tobacco use by partnering on one (1) activity per contract year.

What Will be Measured	Documentation/ Data Source(s)	Baseline & Target	Direction of Change	Completion Date
		Starting point: End target/goal:	Increase, decrease or maintain	

Activities	Lead Personnel Assigned	Key Partners Assigned	Quarterly Progress
			Q1 Q2 Q3 Q4

Partner Activity with NAPA
Assist Nutrition and Physical Activity Program (NAPA) in their efforts to improve nutrition and physical activity by partnering on one (1) activity per contract year.

What Will be Measured	Documentation/ Data Source(s)	Baseline & Target	Direction of Change	Completion Date
		Starting point: End target/goal:	Increase, decrease or maintain	

Activities	Lead Personnel Assigned	Key Partners Assigned	Quarterly Progress
			Q1 Q2 Q3 Q4

DELIVERABLE #6: POLICY AND SYSTEMS CHANGE

Partner with two (2) organizations or systems to achieve increased breast, cervical, and colorectal cancer screening rates in the general population by implementing at least two (2) of the following activities in each site:
(a) Encourage coverage and/or expanded benefits for cancer screening
(b) Encourage adoption of policies that support preventive care (eg., time off for cancer screening)
(c) Support adoption/expansion of wellness program
(d) Increase awareness of the need and benefits of cancer screening

ACTIVITY 1 (list which 2 activities implemented:)

What Will be Measured	Documentation/ Data Source(s)	Baseline & Target	Direction of Change	Completion Date
		Starting point: End target/goal:	Increase	

Activities for Organization/System 1:	Lead Personnel Assigned	Key Partners Assigned	Quarterly Progress
			Q1 Q2 Q3 Q4

ACTIVITY 2 (list which 2 activities implemented:)

What Will be Measured	Documentation/ Data Source(s)	Baseline & Target	Direction of Change	Completion Date
		Starting point: End target/goal:	Increase	

Activities for Organization/System 2:	Lead Personnel Assigned	Key Partners Assigned	Quarterly Progress
			Q1 Q2 Q3 Q4

DELIVERABLE #6: POLICY AND SYSTEMS CHANGE

Seek and track local-level policy changes related to the Montana CCC Plan priorities. List local-level policy changes regarding important cancer control outcomes including physical activity, nutrition, tobacco, screening, tanning, insurance coverage, and professional education.

List:

Increase colorectal screening by assisting a minimum of one (1) clinician office during the contract year to implement the *How to Increase Colorectal Cancer Screening Rates in Practice Toolbox* as documented on Toolbox Forms 1 & 2.

What Will be Measured	Documentation/ Data Source(s)	Baseline & Target	Direction of Change	Completion Date
	Forms 1 and 2	Starting point: End target/goal:	Increase	

Activities	Lead Personnel Assigned	Key Partners Assigned	Quarterly Progress
			Q1 Q2 Q3 Q4

OPTIONAL ACTIVITY 1					
Evidence Base/Rationale					
What Will be Measured	**Documentation/Data Source(s)**	**Baseline & Target**		**Direction of Change**	**Completion Date**
		Starting point: End target/goal:		Increase, decrease or maintain	
Optional Activity		**Lead Personnel Assigned**	**Key Partners Assigned**	**Quarterly Progress**	
				Q1 Q2 Q3 Q4	

OPTIONAL ACTIVITY 2					
Evidence Base/Rationale					
What Will be Measured	**Documentation/Data Source(s)**	**Baseline & Target**		**Direction of Change**	**Completion Date**
		Starting point: End target/goal:		Increase, decrease or maintain	
Optional Activity		**Lead Personnel Assigned**	**Key Partners Assigned**	**Quarterly Progress**	
				Q1 Q2 Q3 Q4	

Quarterly Report of In-Kind Donations and Non-Federal Matching Funds

This form tracks non-federal in-kind contributions and matching funds by groups or individuals of their time, travel expense, or other goods or services donated in support of your regional Montana Cancer Control Programs.

- Match funds must not include contributions from any other federally assisted program or be paid by the federal government under another award.
- If an annual contribution is received, such as an Avon grant, show annual amount; do not report annual amounts on more than one quarterly report.
- Do not include donations reported to the Montana Cancer Control Coalition.
- If using WORD, you may add additional rows to the e-version of this table. Any similar table in another software program will do. Examples, values and definitions are shown below.
- Select ONE category per donation: "Screening" or "Coalition/Education/Outreach".

Use Your Best Estimate for Value of Each Item

Wage Estimates from US Dept of Labor http://stats.bls.gov/oes/current/oes_mt.htm

Examples of reportable donations	
Meeting/Office space	$50/hour or $125/meeting
Copies of Documents/flyers/etc.	10¢/page
Office or media equipment	$25/hour
Food or drinks	$ actual value
Contributions from private for-profit entities	$ actual value
Donations from national or professional organizations	$ actual value
Donated media	$ actual value
Donated educational or promotional supplies	$ actual value
Administrative, overhead, computer or indirect charges	$ actual value

Estimated hourly rates for donated staff, supervisory and volunteer time			
Administrative Support	$15.60	Librarians	$23.40
Administrative Service Manager	$23.17	Media/Communications Worker	$11.74
Bookkeeping/Accounting Clerks	$11.23	Medical Director	$97.50
Chief Executive (private, public org's)	$91.00	Medical / Health Services Manager	$45.50
Dietitians	$26.00	Medical Social Worker	$26.00
Educational professionals	$26.00	Nurse Practitioners	$39.00
Executive Directors – Non-profit Organizations	$45.50	Nurses - Registered	$32.50
Faculty / Researcher / Scientist	$52.00	Pharmacists	$52.00
Grant Writer	$26.00	Physicians – Assistant	$30.50
Governmental Agency Official	$45.50	Physicians - General	$104.00
Governmental Agency Staff	$26.00	Physicians - Specialist	$130.00
Health Care Practitioner & Technical Occupations	$28.60	Private Corporation Staff	$52.00
Health Educator	$20.80	Professional Association Staff	$32.50
Legal Support Workers	$19.90	Tumor Registrar	$26.00
Legislator - State	$26.00	Volunteer	$13.00

MONTANA CANCER CONTROL PROGRAMS

PO Box 202951 Helena, MT 59620

Date	Select Only One		Contributor/ Source (Name of Individual or Organization)	List Dollar Amount								
	Screening	Coalition/ Edu/ Outreach		Cash	Earned Media	Travel	Labor	Space	Food	Supplies	Other	Other Description

Signature:_____ Date:_____

Regional Cancer Control Specialist